The Joint Task Force on the HIV Epidemic

"A Second Decade Response to HIV/AIDS in San Francisco"

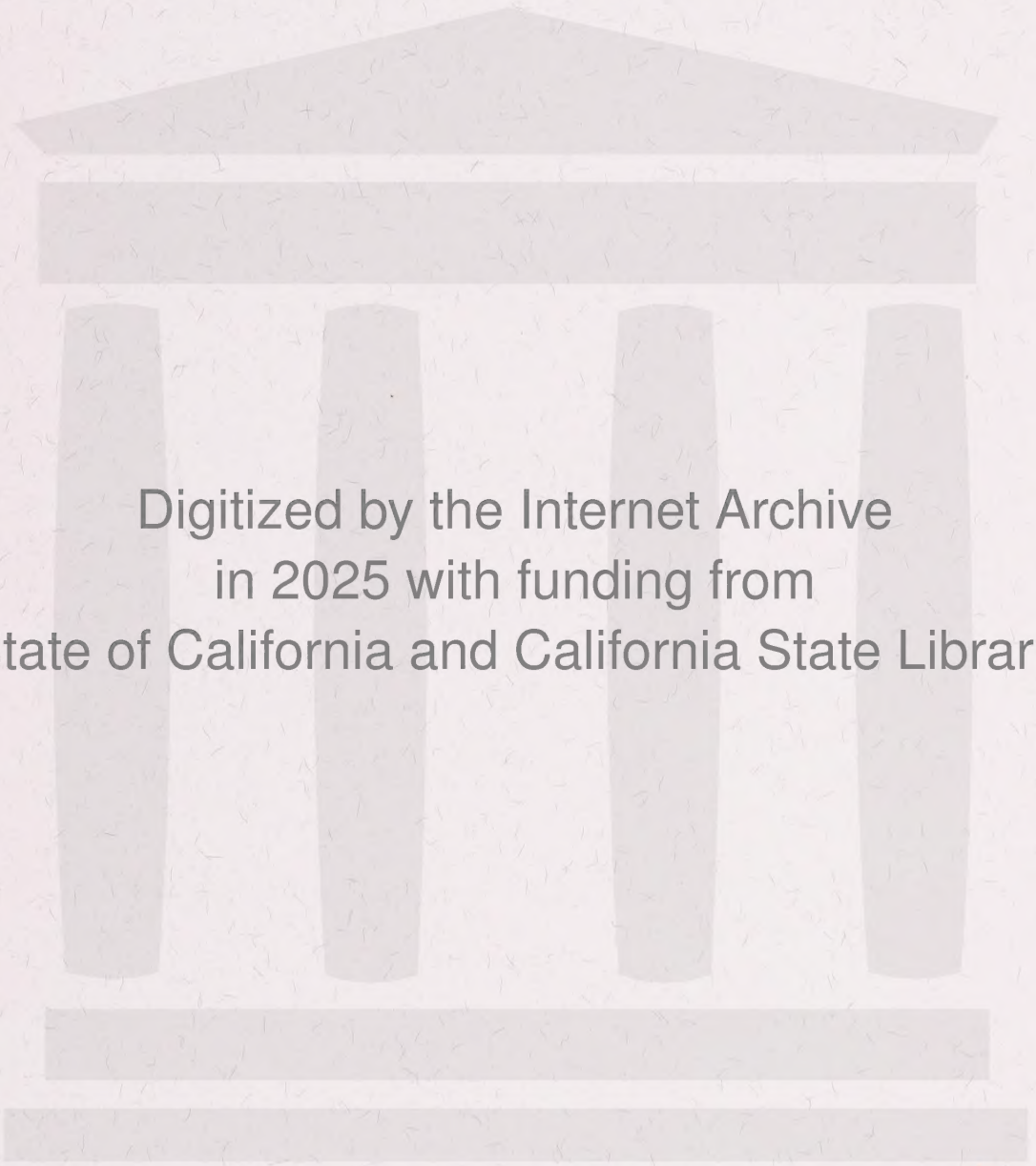
Mayor Frank M. Jordan

San Francisco Board of Supervisors

Angela Alioto, President

Sue Bierman
Annemarie Conroy
Terence Hallinan
Tom Hsieh
Barbara Kaufman
Willie B. Kennedy
Susan Leal
Bill Maher
Carole Migden
Kevin Shelley

December 1994



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JOINT TASK FORCE ON THE HIV EPIDEMIC
CITY AND COUNTY OF SAN FRANCISCO

December 1, 1994

The Honorable Frank M. Jordan, Mayor
The Honorable Angela Alioto, President, Board of Supervisors
Members of the Board of Supervisors

Dear Mayor Jordan, Board of Supervisors President Alioto and Members of the Board of Supervisors:

On February 22, 1993, Ordinance 75-93 creating the Joint Task Force on the HIV Epidemic was passed as the result of an historic joint effort on the part of the Mayor and the Board of Supervisors. In October of 1993, the Joint Task Force on the HIV Epidemic began its year-long work to "advise the Board of Supervisors and the Mayor on legislation and policy related to the City's HIV policies and programs." Section 5.162-A, Powers and Duties, of Ordinance 75-93, charges the Joint Task Force to "prepare and submit to the Board of Supervisors and the Mayor an annual report on the state of the HIV epidemic, which shall include a review and evaluation of the services and programs in place to respond to the epidemic, any outstanding needs, and recommendations and plans as to a program for responding to the epidemic."

We have fulfilled our charge and are pleased to present the enclosed report, ***A Second Decade Response to HIV/AIDS in San Francisco***, to the City and County of San Francisco. During the thirteen years that we as a community have been coping with this epidemic, creativity, energy and tremendous efforts have shaped the "San Francisco Model" of service delivery. Now, in this second decade, it is time to develop *new* strategies and *different* structures in order to better provide appropriate service to people infected and affected by HIV.

It is *critical*, in the view of the Joint Task Force, that our policy recommendations be taken seriously and implemented with due speed. As noted in our report, the issues are complex, the needs are great, the political struggles unfortunate and the funding less than ideal. Still, we must – as policy makers, service providers, activists and consumers – work together to create a centrally planned, coordinated system for San Francisco that offers new levels of high quality, accessible HIV service to all populations in need. San Francisco must continue to provide a model response to a pandemic that, terribly, shows no signs of being eliminated in our lifetime.

We are honored to have served the Joint Task Force on the HIV Epidemic on behalf of the City and County of San Francisco. As the Joint Task Force was convened for one year only, Task Force members thank you for this opportunity and offer our sincere desire to work with you as individuals in the implementation of the recommendations contained herein.

For the Joint Task Force on the HIV Epidemic,

Sandra Hernandez, M.D.
Chairperson

Eileen Hansen
Vice-Chairperson

JOINT TASK FORCE ON THE HIV EPIDEMIC

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ACKNOWLEDGEMENTS

Without the energy and support of *many*, this report of the Joint Task Force on the HIV Epidemic would not have been possible. We gratefully acknowledge the foresight of San Francisco's Mayor and Board of Supervisors in jointly creating the Joint Task Force.

We appreciate the support of the offices of Mayor Frank M. Jordan and Board of Supervisors President Angela Alioto throughout the tenure of the Joint Task Force. In particular, we thank Supervisor Alioto for offering the in-kind assistance of Intern Jen Kates. Jen's help during the early stages of writing the report was crucial to our efforts.

The Department of Public Health supplied the in-kind services of staffmembers Dick Bufania, Carmen Vazquez and Dana Van Gorder, and the AIDS Office offered enormous support for our efforts to publicize and distribute the draft work of the Joint Task Force so that we could involve as many people as possible in our process.

The input of those who contributed to our report through public testimony, interviews or written comment was tremendously valuable. We also thank the staffmembers of HIV organizations who provided materials for our research and assessment. The continuing efforts of both public and private HIV service providers to make a difference in the lives of people with HIV are truly outstanding.

Eileen Hansen, Vice-Chair of the Joint Task Force, coordinated the efforts of the group and wrote the final report with the *invaluable* commitment and assistance of Joint Task Force Member Kristin Neil and AIDS Legal Referral Panel (ALRP) Public Policy Intern Rachel Maddow. We owe special gratitude to Eileen's agency, ALRP, for its patience with our process and its generosity with her time.

Finally, and most importantly, we pay tribute to those who have gone before us – those who have met the challenge HIV has presented to us through their activism, advocacy and organizing – and those who have not lived long enough to see society deal with AIDS by confronting its homophobia, its racism, its classism, its sexism and its moral judgements.

We especially acknowledge the efforts of people with HIV/AIDS who, while struggling with the disease themselves, continue the fight to stop the epidemic for us all. We dedicate this report to two members of the Joint Task Force on the HIV Epidemic who died of AIDS-related causes prior to completion of this report, *Charles Caufield and William "Brandy" Moore.*

LISTING OF MEMBERS

JOINT TASK FORCE ON THE HIV EPIDEMIC

A Second Decade Response to HIV/AIDS in San Francisco

LISTING OF MEMBERS

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Aide to San Francisco Board of Supervisors President Angela Alioto
HIV Health Services Planning Council

HISTORY

HISTORY

The Joint Task Force on the HIV Epidemic was *jointly* created by Mayor Frank M. Jordan and the San Francisco Board of Supervisors to meet for one year in order to "advise the Board of Supervisors and the Mayor on legislation and policy related to the City's HIV policies and programs." We began working in October of 1993 to carry out the duties assigned to us, which included the following (as specified in Ordinance 75-93, reproduced in Appendix A of this report):

A) "Prepare and submit to the Board of Supervisors and the Mayor an annual report on the state of the HIV epidemic, which shall include a review and evaluation of the services and programs in place to respond to the epidemic, any outstanding needs, and recommendations and plans as to a program for responding to the epidemic;

B) "Assist in coordinating information, activities and goals among existing City and County AIDS/HIV advisory and planning groups;

C) "Assist in improving the delivery of, and efficiency in the provision of, medical and prevention services, including HIV early intervention and primary medical care, and to identify and encourage consolidation opportunities for program and administrative services;

D) "Assist the Mayor's Office in organizing official delegations to go to Washington, D.C. and Sacramento to lobby for federal and state monies for City AIDS services and HIV-related programs, and to expand public-private partnerships to meet the growing needs of the HIV epidemic."

The Joint Task Force on the HIV Epidemic was composed of twenty-five members, including the Mayor or his designee, the President of the Board of Supervisors or her designee, the Director of the Department of Public Health, the County Health Officer or her designee, the Director of the AIDS Office of the Department of Public Health, eleven members appointed by the Board of Supervisors, eight members appointed by the Mayor and one member appointed by the San Francisco Health Commission.

Members of the Joint Task Force were selected to be "broadly representative of the ethnic, racial, gender, age and sexual orientation diversity of the City and County," with persons appointed "from varying backgrounds who have demonstrated abilities, vision or experience in dealing with the AIDS crisis." Our past and ongoing experiences as activists, advocates, providers, policy makers and consumers within San Francisco's HIV

system enabled us to reflect on the effectiveness of that system. Nine Joint Task Force Members self-disclose as HIV-infected with five having AIDS, thirteen of us are people of color, most of us self-identify as gay, lesbian or bisexual, eight of us are women and our ages range from 22 to 49.

The charge of the Joint Task Force was large and we took our work seriously. However, because we were neither staffed nor provided with funding of any kind, we were continually hampered in our ability to accomplish the duties mandated to us. Interestingly, the challenges faced by the Joint Task Force are indicative of the epidemic today. The fragmentation and weariness of the HIV service delivery system was reflected in our own struggle to find consensus regarding politically sensitive and complex solutions, while membership constantly waned or changed due to death, illness, burnout and overcommitment.

Over the course of a year, two of our members died of AIDS-related conditions and several were hospitalized. One member's partner died of AIDS-related conditions, one member went on HIV-related disability, two members' HIV agencies folded and many of our close friends, co-workers and acquaintances died. Several of us are moving into our second decade of activism or work within the HIV system in San Francisco. We continue to perform this work within the context of the loss of tremendous numbers of friends and loved ones and the need for continuing care of friends, co-workers, lovers and ourselves. We grapple with the knowledge that in spite of our best efforts, young people in San Francisco are not getting the message about prevention and are seroconverting in growing numbers, that San Francisco is experiencing 1000 new infections in gay men each year, and that many gay men who have been negative for over a decade and who have long practiced protected sex are now engaging in unsafe behaviors and beginning to seroconvert.

This report comes not only from members of the Joint Task Force, but from the voices and consensus of many. During our work over fourteen months (we extended our year's tenure by two months), we spoke with many individuals and representatives of organizations. Our internal process included meeting on a monthly basis for six months and then meeting at least twice monthly for eight months. We also divided the Joint Task Force into three committees to further develop our work. We convened fourteen external meetings, including a public forum, four focus groups and nine interviews. In addition, a public hearing was held to solicit feedback on the published draft report prior to its finalization.

Even so, our attempts to obtain community input – particularly from people with HIV who are not affiliated with an HIV organization – were not as successful as we had hoped. We saw a far greater response to requests for information and feedback from providers than from clients or potential clients. The low level of involvement in our public meetings was, we believe, indicative of the difficulties in bridging the differences and gaps between policy makers and service providers and HIV-infected communities.

This is an ongoing problem and must be dealt with if the voices of consumers of HIV services are to be heard regarding evaluation of those services. Based on our successes and failures in seeking input for this report, we suggest to service providers and the City and County when seeking public feedback that they work with existing, well-respected grassroots organizations based in the targeted community to design the logistics and overall tone of meetings in a way that will be most comfortable for the target population.

We *strongly* believe that our conclusions and recommendations must be acted upon if the City and County of San Francisco is to develop innovative and effective HIV services appropriate for this stage of the epidemic. We must continue to fight this scourge with every resource we can find and with every ounce of energy we can muster. We must acknowledge the changing demographics of the epidemic and respond appropriately. We must look beyond protecting our "turf," our jobs, our ideas. Instead, we must focus on protecting the present and future of our City, our communities, our families and lovers, our friends, and ourselves.

Therefore, the recommendations contained in this report *must* be expediently implemented by the Mayor and the Board of Supervisors. The Joint Task Force on the HIV Epidemic does not intend for its report to go ignored on a dusty shelf. This Joint Task Force was convened to advise the Mayor and the Board of Supervisors. We have now done so and we expect that the expertise contained in this report – expertise gathered from consumers, providers, policy makers, concerned individuals, advocates and activists involved in the fight against HIV for many years – will be valued and utilized on behalf of people infected and affected by HIV.

We urge service providers and other members of the "HIV/AIDS community" of San Francisco to utilize this report as a tool for developing new and better responses to the epidemic as it continues to change in complexity. All of us – together – must advocate that the recommendations in this report be implemented. It's time for ***A Second Decade Response to HIV/AIDS in San Francisco.***

The Joint Task Force on the HIV Epidemic
December 1, 1994

EXECUTIVE SUMMARY

JOINT TASK FORCE ON THE HIV EPIDEMIC

A Second Decade Response to HIV/AIDS in San Francisco

EXECUTIVE SUMMARY AND RECOMMENDATIONS TO THE MAYOR AND BOARD OF SUPERVISORS

The Joint Task Force on the HIV Epidemic, composed of twenty-five members "broadly representative of the ethnic, racial, gender, age and sexual orientation diversity of the City and County from varying backgrounds who have demonstrated abilities, vision or experience in dealing with the AIDS crisis," (Ordinance 75-93) met for fourteen months to develop ***A Second Decade Response to HIV/AIDS in San Francisco***. We reviewed the response of the City and County of San Francisco to the first thirteen years of the HIV pandemic. We confronted the challenges of the second decade and assessed the differing HIV-related needs of our various communities, along with the demands placed on HIV service providers, in order to create a plan to move us forward to the next stage of response.

San Francisco has experienced enormous loss, along with individual and community-wide trauma, and somehow in the face of that reality, we must find the inner strength, the financial resources and the community will to acknowledge that our current model of service provision is no longer adequate. We are now at a point in confronting the epidemic where *new* strategies and *different* structures are *absolutely critical* if we are to continue providing appropriate services to people infected and affected by HIV. The issues are complex, the needs are great, the political struggles unfortunate and the funding less than ideal. It will take all of us working in unison to create a centrally planned, coordinated system that offers new levels of high quality, accessible HIV service to all populations in need.

The following summary recommendations are selected from the text of this report (including Appendices) and made *to the Mayor and Board of Supervisors of the City and County of San Francisco or the appropriate body within San Francisco's HIV service delivery system*. All community-based HIV service agencies and City departments delivering HIV services, particularly the Department of Public Health, the Department of Social Services and the San Francisco Redevelopment Agency, will play an integral role in implementing these recommendations. For further detail and additional recommendations, please refer to the body of the report. These recommendations, along with the full text, comprise the proposal by the Joint Task Force on the HIV Epidemic for the creation of ***A Second Decade Response to HIV/AIDS in San Francisco***. The 40 recommendations to follow are not specifically prioritized, but rather follow the chronology of the report.

The City and County of San Francisco, or the appropriate body within San Francisco's HIV service delivery system, must:

PLANNING

1. Address the elements of gaps in care, quality of service and access to services in all aspects of HIV service delivery and planning, with a focus on the specific needs of specific populations.

2. Involve people with HIV in all aspects of the planning and design of HIV programs, in the delivery of services and in the assessment and evaluation of services. Ensure youth participation in all efforts.

3. Recognize the crucial roles caregivers and families play in the network of care; address families as a unit in all planning, budgeting and service decisions; continue needed services to families after their loved one has died.

ADMINISTRATIVE PLANNING

4. Develop a permanent, staffed, authoritative body, seated within an existing but expanded structure, to be charged with HIV strategic planning and oversight of HIV service delivery.

5. Assess the success of efforts to implement the recommendations contained in this report. We request that the Mayor and Board of Supervisors, in coordination with the Department of Public Health's AIDS Office and the San Francisco Health Commission, hold a public hearing nine months after issuance of this report (by 09/01/95), and thereafter, every twelve months from that date.

6. Develop a mechanism through which current citywide HIV/AIDS policy and advisory groups can work together to restructure themselves, coordinate and/or consolidate in order to avoid duplication, address issues of "turf," maximize resources and avoid burnout. Develop a model for communication and coordination between citywide HIV/AIDS policy and advisory groups and public agencies, in particular the Department of Public Health, the AIDS Office and the Department of Social Services.

7. Distribute to citywide HIV/AIDS policy and advisory groups guidelines explaining the purpose, roles and responsibilities of each group and its participants and outlining conflict of interest policies. Consistent adherence to these guidelines must be ensured.

8. Support and encourage the San Francisco Health Commission's continued and active fiscal oversight and involvement in HIV health policy and planning issues.

LEGISLATION AND ADVOCACY

9. Increase lobbying efforts in Sacramento and Washington by the Mayor and Board of Supervisors for solid, ongoing funding and key legislation (including continued

reauthorization of the federal Ryan White CARE Act and increased HIV and health appropriations) for San Francisco's HIV prevention/education, research, housing, treatment and service delivery needs, for efforts to increase the collection of demographic data on underserved populations and for legalization of needle exchange.

FISCAL PLANNING

10. Commit to raising *new* private funds and public revenues to support the City and County of San Francisco's response to the HIV epidemic, in a public-private partnership.

11. Ensure that HIV services not be jeopardized by reorganization and budget cuts during the fiscal year. In order for San Francisco to receive its full allocation from federal and state agencies, the budget process must – at a minimum – hold harmless the portion of the General Fund used to provide or leverage funding for HIV services.

CONTRACTING

12. Explore the cost-effectiveness of AIDS Office contractors jointly purchasing goods and services; the AIDS Office should implement such a mechanism if it is found to be cost-effective.

13. Develop a new mechanism for expedited approval of contracts and expedited payment for services rendered. Expedite the current Department of Public Health internal review of contracting policies and procedures.

RESEARCH

1. Coordinate efforts of researchers at the University of California San Francisco and elsewhere with community-based organizations, community members and the Department of Public Health to define HIV/AIDS research priorities, disseminate new information and optimize opportunities to generate research funding. Establish a centralized database to collect epidemiological and demographic information in order to inform research efforts.

2. Increase behavior-focused research as well as population-specific studies prioritizing women, people of color and youth – in addition to continuing research on gay men, especially gay men of color; increase access to clinical trials for these populations.

3. Investigate woman-to-woman HIV transmission, behaviors of women who self-identify as lesbians and the effects of HIV on young women; examine treatment protocols studied in men to determine if they are appropriate and effective for women; pursue innovative technology to prevent oral-vaginal HIV transmission.

4. Expand research and evaluation efforts to include non-western medical traditions.

PREVENTION/EDUCATION

1. Target clear and consistent prevention campaigns toward people with high risk behaviors, stressing the maintenance of good health rather than focusing solely on the prevention of disease. Use increased data collection to assist planning efforts.

2. Implement community-based, community-specific prevention interventions. Evaluate the effects on individual and group behavior change of strategies that are interpersonal and include multiple interventions, as well as large-scale media campaigns. Ensure that prevention efforts are sensitive to the diverse needs of differing populations.

3. Support maintenance of safer sexual behavior through a continuum of prevention/education services. Address the complex and respective issues of HIV-negative and HIV-positive gay men with regard to prevention and access to community support.

4. Support and implement recommendations contained in the recent *HIV Prevention Planning Council Draft Plan*, in the *Mayor's Call to Action on the HIV Epidemic* (1990), and in the *People of Color and HIV/AIDS Report* (1993).

5. Link prevention/education services with substance abuse and mental health services. Address issues of sexual violence, partner abuse and economic empowerment, particularly with regard to women. Include prevention/education services in jails, prisons, schools and youth-focused environments outside of school settings.

6. Support continued availability of anonymous HIV-antibody testing; ensure that counseling is an integral part of *all* HIV-antibody testing.

SERVICE DELIVERY

1. Guarantee that all HIV services are provided in a manner sensitive to issues of culture, race, ethnicity, class, gender, sexual orientation, immigrant status, language, religion and age. Create greater accessibility to services by focusing attention on concerns related to substance abuse, mental health and physical ability. Provide services to people at all points on the continuum of HIV infection.

2. Expand services to underserved populations through increased links with non-HIV related community facilities such as churches, recreational facilities and schools; increase outreach and services in jails and prisons.

PRIMARY MEDICAL CARE

3. Expand the concept and availability of medical care to include a broad range of treatments, including western medical models, holistic therapies, acupuncture and other traditions of medical practice.

4. Address primary care issues specific to women, transgendered people and incarcerated populations. Expand low-cost HIV/AIDS treatment options and home-based attendant and skilled nursing care.

MENTAL HEALTH SERVICES

5. Increase mental health services that are appropriate with regard to issues of culture, race, ethnicity, class, gender, sexual orientation, immigrant status, language, religion and age. Increase mental health services and support groups specifically for women, youth, people with multiple diagnoses, rape survivors, homeless people and transgendered people. Address the mental health needs of caregivers and people with late- and end-stage AIDS. Address issues surrounding the interconnection of substance abuse, mental health and HIV. Develop services to respond to community-wide loss.

6. Investigate how the various gay/bisexual male communities in San Francisco cope with long-term loss due to AIDS, how overall community well-being impacts individual seroconversion and how the focus on short-term versus long-term strategies of HIV care affects the mental health of individuals and the community.

SUBSTANCE ABUSE TREATMENT

7. Increase the quantity and accessibility of substance abuse treatment slots, especially detox and methadone maintenance, in order to provide treatment "on demand" to anyone who seeks such services. Specific services must be made available to homeless people, transgendered people, women with and without children, people with multiple diagnoses, people who are incarcerated, and survivors of rape, sexual abuse and/or physical abuse.

8. Integrate HIV prevention/education into drug and alcohol treatment programs. Provide HIV harm reduction outreach, including needle exchange, to persons using substances who choose not to enroll in substance abuse treatment programs. Increase attention to the problem of substance abuse relapse among people with HIV.

HOUSING

9. Explore the development of an "AIDS Housing Development Corporation" to take responsibility for the purchase, renovation, and property management of buildings purchased with Housing Opportunities for People With AIDS (HOPWA) or other housing funds. These efforts must be coordinated with the efforts of those

currently engaged in HIV/AIDS housing service, including existing low-income housing development corporations providing HIV housing, residents of HIV housing units, HIV housing service providers, the HOPWA Loan Committee and the HIV/AIDS Housing Network. Implement the recommendations of the AIDS Office's *San Francisco Five-Year Housing Plan*; evaluate implementation of the proposed housing services system outlined in the *Housing Plan* in twelve to eighteen months.

10. Expand housing for people with AIDS Dementia Complex, transgendered people, people with multiple diagnoses, people actively using substances and people with AIDS living with their families. Expand availability of hospice care for all people with AIDS. Increase flexibility of eligibility criteria for women's beds in transitional housing. Include respite care in housing development. Include short-term, emergency and permanent housing and link with mental health care and other social services.

COORDINATED CONTINUUM OF CARE

1. Maintain and foster a community-driven approach to HIV services that embraces a client-centered, coordinated plan for community collaboration and overall well-being. Issues related to spirituality, as well as to physical and emotional health, should be included in this approach.

2. Create, support and implement a coordinated intake, evaluation and information referral system for individuals accessing HIV services.

3. Expand systemwide HIV case management to facilitate access to the medical care and social service systems.

4. Standardize job descriptions, pay scales and assessment tools across HIV service agencies; standardize definitions of "client advocate" and "case manager;" develop definition of "standard of care" and guidelines for implementation that take into account differences in agency funding and types of service provision.

5. Develop and provide an extremely user-friendly, electronically linked computer database for all HIV/AIDS service providers that facilitates HIV service provision while prioritizing the absolute maintenance of confidentiality protections.

6. Explore the concept of centralized service centers, developing a main service center and neighborhood/target population satellites, with multiple services available at each of these centers.

7. Create a coordinated volunteer recruitment, referral, training and retention system for HIV services.

A Second Decade Response to HIV/AIDS in San Francisco

JOINT TASK FORCE ON THE HIV EPIDEMIC

A Second Decade Response to HIV/AIDS in San Francisco

I. INTRODUCTION

The City and County of San Francisco continues to experience both profound loss and increasingly high demand for service provision in its attempt to survive the HIV pandemic. In reviewing the past thirteen years and confronting the challenges of the second decade, the Joint Task Force on the HIV Epidemic realized the urgent imperative to assess:

1) the appropriateness of the current response to the HIV epidemic by the City and County of San Francisco;
2) the differing HIV-related needs of our various communities; and
3) the demands placed on HIV service providers.

Over the last thirteen years, approximately 200 agencies began providing HIV services in San Francisco. These services arose as the result of important grassroots community efforts to address particular areas of need, including services for populations who were underserved by the main service agencies. Still today, the need is *critical* for HIV prevention/education, care and research that address culture, race, ethnicity, class, gender, sexual orientation, immigrant status, language, religion and age-specific needs. With diminishing funding, increased competition for funding and the expected changes in health care delivery, some individuals and organizations have called for the "consolidation" of HIV service organizations. However, if consolidation is defined as the elimination of HIV service agencies, it is *not* an acceptable solution. Rather, a reorganized service delivery system that provides effective services to all people with HIV and others affected by the epidemic is what a forward-thinking San Francisco HIV/AIDS plan *must* be about.

The "San Francisco Model" for HIV service delivery must be able to evolve and adapt to the continually changing epidemic. Toward that end, the community-wide impact of ever increasing numbers of people living longer with HIV or AIDS warrants immediate attention. This model requires a variety of *specific* services for *specific* populations – planned and provided by those who are members of those populations – along with a unique vision of comprehensive, coordinated, coherent care. In the planning and design of programs, in the delivery of services and in the assessment and evaluation of services, there must always be more than token representation of people with HIV.

The overwhelming majority of people with HIV in San Francisco continues to be gay and bisexual men of all colors. Accessibility of services for this population – along with attention to the traumatic effects of the epidemic on the lesbian/gay/bisexual/ transgendered communities – is critical. People of color make up approximately 50% of San Francisco's population. With the numbers of people of color with HIV rising, again

accessibility is key – with heightened sensitivity to racial, ethnic and cultural differences. In addition, the spread of HIV among injection drug users and the growing proportion of people affected by substance abuse requires increased attention to service provision for this population. The needs of people with HIV who are members of more than one "community" must also be acknowledged and addressed.

A comprehensive system for HIV care must respond to populations both infected *and* affected by the epidemic. The needs of caregivers and families involved with people with HIV have largely been overlooked. Future planning efforts must recognize the crucial role of caregivers in the network of care. Given that many caregivers are themselves HIV-infected, the loss of caregivers due to burnout or death and our decreasing ability to replace volunteers is of serious concern. Additionally, the extended family network must be addressed as a unit when looking at all planning, budgeting and service decisions. For example, any comprehensive transportation plan must address the needs of women traveling with children; child care must be made available in conjunction with all services; and assistance must be given to the care and future planning needs of children who are potential orphans of the HIV epidemic. Partners, parents and children of HIV-infected individuals may have many of the same basic needs as people with HIV. These family members must have access to services while caring for a person with AIDS *and* after their loved one has died.

In the year-long work of the Joint Task Force, we assessed gaps in service, quality of care and access to care. We looked at both publicly and privately funded services. We explored issues of accountability, coordination and collaboration among service providers. Our review is based on an analysis of the current response to the HIV epidemic within the entity of the City and County of San Francisco. However, our report does not do all that we anticipated. We see our efforts as merely the beginning of what must be an ongoing, comprehensive commitment on the part of the City and County of San Francisco to plan and evaluate the need for a changing response to San Francisco's changing epidemic. Further inquiry must be directed, for example, toward the effects of "managed care" on HIV service delivery, a fiscal analysis of HIV service delivery, the potential for consolidating duplicated services without compromising quality or accessibility, the physical infrastructure (i.e. building safety, earthquake preparedness) of our system, further development of public and private resources within the context of waning political support for our efforts, the long-term feasibility of relying on Ryan White CARE Act funding, and more.

With limited resources and increasing needs, any new HIV/AIDS plan must incorporate a total effort by the City and County, the private sector and community-based agencies. In order to meet this goal, the Joint Task Force on the HIV Epidemic offers 40 recommendations to be expediently implemented by the City and County of San Francisco in the creation of ***A Second Decade Response to HIV/AIDS in San Francisco***. We challenge those who come after us to pick up our work and move us all forward to the *next* stage of response to HIV/AIDS in San Francisco.

II. PLANNING

Recognition of the need for comprehensive planning, oversight and assessment of HIV services in San Francisco is of utmost importance as we attempt to develop the financial and political resources to provide ***A Second Decade Response to HIV/AIDS in San Francisco***. HIV planning efforts in the City and County of San Francisco must involve administrative issues, legislation and advocacy, budgeting issues and the process of contracting for services. For increased clarity in addressing these critical issues, this section has been divided into four categories of planning, with each category containing issue-specific recommendations.

ADMINISTRATIVE PLANNING

The lack of a centrally planned, coherent, coordinated system is a major problem in the current "San Francisco model" of service delivery. In order to develop short- and long-term HIV-focused plans for the City and County of San Francisco, a specific body must be charged with citywide HIV planning. Such a body must have secured funding and must include the active participation of all appropriate City departments and people with HIV. Currently, some specifically targeted planning is carried out by several different bodies, most notably the Health Services Planning Council (also known as the CARE Council or the Ryan White Council), the HIV Prevention Planning Council and the Department of Public Health's (DPH) AIDS Office. We support these critical efforts and strongly recommend that the plans developed by these bodies be implemented by the City and County of San Francisco.

RECOMMENDATIONS:

- In the changing environment of health care delivery, HIV strategic planning and general oversight of service delivery must be the top priority of a permanent, staffed, authoritative body. This critical centralized planning capability may be seated within existing, *but expanded*, structures. Such an effort is not meant to diminish the authority of existing structures or the work of other bodies engaged in planning efforts. Rather, we believe that a coordinated – and centralized – effort will increase our capability to develop a proactive approach to HIV planning.

- This planning process must include the active participation of all City departments that provide HIV-related services. Department directors must enhance their planning capabilities regarding HIV by implementing coordinated planning efforts, hiring appropriate staff and assessing where funding streams can be linked. The City and County must secure expanded funding for this planning and general

oversight function. People with HIV must be involved in all aspects of the planning and design of programs, in the delivery of services and in the assessment and evaluation of services.

- In order to assess the success of efforts to implement the recommendations contained in this report, we request that the Mayor and Board of Supervisors, in coordination with the Department of Public Health's AIDS Office and the San Francisco Health Commission, hold a public hearing nine months after issuance of this report (by 09/01/95), and thereafter, every twelve months from that 09/01/95 date. This public hearing will be a forum for comprehensive review of all HIV-related planning efforts and documents, along with recent service/needs assessments. It shall be the duty of the President of the Board of Supervisors to assign to the appropriate Board Committee the convening and organizing of this forum. In preparation for this hearing, the Mayor is expected to distribute to all relevant City and County departments a copy of this report, with instructions to department directors to inform the Mayor as to how this report has been implemented within their particular department's mission-driven budget, planning process and delivery of service. All departments will be expected to take part in the public hearing to inform the public of their success in implementing this report.

- The Joint Task Force supports efforts of the current citywide HIV/AIDS policy and advisory groups to address specific needs and to contribute to the recommended central planning body. In addition, the Department of Public Health must develop a mechanism through which these policy and advisory groups can work together to restructure themselves, coordinate and/or consolidate in order to avoid duplication, address issues of "turf," maximize resources and avoid burnout. The Director of the AIDS Office will be responsible for reviewing the success of the mechanism developed. Additionally, HIV/AIDS policy and advisory groups should assist in bringing both service providers and people with HIV/AIDS to the table to help create a sensitive and appropriate plan in the context of consolidation and managed care.

- We support and encourage the San Francisco Health Commission's continued and active oversight regarding how HIV dollars are spent in San Francisco. We also support and encourage the continued active role of the San Francisco Health Commission in HIV health policy issues and specifically recommend that the Commission strengthen its ties with the Ryan White CARE Council and the HIV Prevention Planning Council in order to better contribute to coordinated HIV planning efforts for the City and County.

LEGISLATION AND ADVOCACY

If the City and County of San Francisco is serious about its "commitment to fight the scourge of AIDS and HIV, not just by maintaining current effort, but by focusing more

than ever on developing and funding gender and culturally and linguistically appropriate prevention, education, intervention and treatment programs" and by providing "social, health care and other essential services to people with AIDS and HIV, and [by] protect[ing] the rights of these same people to be free from discrimination" (language from Ordinance 75-93, creating the Joint Task Force), then the Mayor and the Board of Supervisors must provide leadership with regard to funding, legislation and policy at the local, state and national levels.

RECOMMENDATIONS:

- There must be pro-active leadership on the part of the Mayor and the Board of Supervisors in lobbying Sacramento and Washington for solid, ongoing funding and key legislation (including continued reauthorization of the federal Ryan White CARE Act and increased HIV and health appropriations) for San Francisco's HIV prevention/education, research, housing, treatment and service delivery needs. Advocacy by community-based organizations is both necessary and underfunded, and efforts to increase funding specifically for advocacy must also be encouraged.

- Active support is needed for state and national efforts to increase the collection of demographic data including country of origin, regarding lesbians, bisexual women, gay men, bisexual men, people of color, legal and undocumented immigrants, transgendered people, the homeless and street-based youth, so that additional HIV prevention/education and direct services can be provided.

FISCAL PLANNING

The implementation of an overall HIV/AIDS plan for the City and County of San Francisco will require substantial public and private funding. Monies must be provided at the federal, state and local levels to support citywide planning, reorganization of services, training of service providers in cultural competency and advocacy for ongoing public health funding. Additionally, funding is necessary to provide technical assistance to community-based organizations in such areas as organizational development, evaluation, personnel issues, financial management, fundraising and grantwriting.

The City and County of San Francisco has developed a series of outstanding HIV programs that have generated matching funds from federal, state and private agencies. These monies constitute the life-blood of the San Francisco HIV service delivery model. Yet, health care for people with HIV and those of limited income is held hostage every year by San Francisco's internal budget process. Continued cuts in budgets that already combine maximized services with fiscal responsibility demoralize both the people who utilize services and overworked service providers. Financial considerations force providers to minimize service to low-income populations and to compromise quality service for all communities. Elected officials cannot balance the budget year after year on the backs of the most vulnerable by interfering with – or halting – their ability to access HIV services and other health care.

The Mayor and Board of Supervisors must acknowledge that "HIV service delivery" includes services that may not appear on the surface to be HIV-related. For example, mental health services, substance abuse services and housing are often just as essential as "primary medical care" to people with HIV. Thus, these services must be protected within the context of preserving HIV services in a variety of City and County departments.

RECOMMENDATIONS:

- The Mayor and Board of Supervisors must provide leadership in raising private money, as well as ensuring public funding for HIV services. A private-public partnership is essential to meet the ever increasing financial requirements to fight the HIV epidemic. We encourage the private sector to become more fully involved in the needs of their communities.

- The current tax structure of the City and County of San Francisco has created an extremely limited tax base and ever-decreasing revenues. The Mayor and Board of Supervisors must commit to securing new revenue for the City and County of San Francisco in order to continue – and expand – San Francisco's commitment to HIV prevention/education, research, housing, treatment and service delivery.

- In order for San Francisco to receive its full allocation from federal and state agencies, the budget process must – at a minimum – hold harmless the portion of the General Fund used to provide or leverage funding for HIV services. HIV services must not be jeopardized with regard to reorganization and budget cuts during the fiscal year.

CONTRACTING

San Francisco's contracting, certification and procurement process must be overhauled. The current process between service providers and the City and County is lengthy, outdated and impossibly cumbersome. It is a disincentive to community collaboration and to private contractors who want to do business in San Francisco. Small community-based organizations are often put in jeopardy because of delays in receiving *approval* for funding, let alone receiving the funding itself.

An evaluation of quality of service, utilization and cost per unit effectiveness should be conducted by the Department of Public Health's AIDS Office in any potential reorganization or assessment of services, with sensitivity to the specific types of service necessary for specific populations. Additionally, DPH and/or AIDS Office issues such as the Request for Proposals (RFP) process, fiscal oversight of contracts and DPH internal and external auditing procedures should be evaluated as expediently as possible within the context of a managed care model of health care delivery in San Francisco.

RECOMMENDATIONS:

- A new mechanism must be developed for expedited approval of contracts and

expedited payment for services rendered. The number of signatures required to sign off on contracts and payments must be greatly reduced. The Department of Public Health is currently reviewing its contracting policies and procedures, including those for the AIDS Office. We urge the Department to expedite its review.

- In order to help reduce the overhead burden on community-based organizations, the AIDS Office should explore the cost-effectiveness of AIDS Office contractors jointly purchasing goods and services; the AIDS Office should implement such a mechanism if it is found to be cost-effective.

- The City and County should also explore the coordination of HIV-related housing contracts through the San Francisco Redevelopment Agency and the Department of Public Health's AIDS Office.

III. RESEARCH

Although the area of HIV/AIDS research was not mentioned within the mandate of the Joint Task Force, members strongly note the importance of research in all aspects of HIV service and prevention/education. The review conducted by the Joint Task Force does not begin to approach a comprehensive study of HIV/AIDS research procedures or practices in San Francisco. However, certain issues related to gaps in access and information must be addressed. Researchers at the University of California San Francisco and elsewhere, community-based organizations, community members and the Department of Public Health should coordinate their efforts to define HIV/AIDS research priorities, disseminate new information and optimize opportunities to generate research funding. As a matter of public health policy and public health leadership, the Department of Public Health should support the continuing efforts of research groups to address unmet needs. A centralized database should be established to collect epidemiological and demographic information in order to inform research efforts.

RECOMMENDATIONS:

- Focus research on behaviors associated with HIV transmission, as well as conducting research on specific population groups hard hit by the epidemic;
- Focus attention and priority on women, people of color and youth – in addition to continuing research on gay men, especially gay men of color. Specifically, this research agenda should:
  - Recruit these disenfranchised communities into clinical trials;
  - Develop new studies specific to these communities;
- Investigate woman-to-woman HIV transmission and examine treatment protocols studied in men to determine if they are appropriate and effective for women; and
- Expand research and evaluation efforts to include non-western medical traditions.

IV. PREVENTION/EDUCATION

The Joint Task Force recognizes that prevention/education is an essential part of the continuum of HIV services. While former prevention efforts defined "high risk" according to identity, a new plan must address prevention needs on the basis of behaviors. Behavior is what puts people at risk – not the fact that they belong to a particular gender or ethnic group. However, cultural, racial, ethnic, class, gender, immigrant status, linguistic, religion, age and sexual identities have bearing on access to information and the assessment of and willingness to take risks in terms of HIV transmission. Prevention planning efforts focused on high risk behaviors should be informed by increased data collection on behavior trends. Given limited resources, prevention/education campaigns should be targeted to those with highest risk behaviors. Campaigns should stress maintenance of good health rather than focusing solely on the prevention of disease. Notwithstanding these targeted efforts, basic prevention information should be available to all people, regardless of their apparent level of risk.

Prevention/education efforts must be appropriate along lines of culture, race, ethnicity, class, gender, immigrant status, language, religion, age and sexual orientation, and must be sensitive to the diversity within, as well as between, populations. These efforts should not be judgmental or moralistic. Advocates express widespread support for sustained peer-based and small group interventions and outreach that give special attention to psychosocial issues underlying behavior change such as grief, self-esteem, personal empowerment, family support and community membership. Community-based and community-specific interventions are best suited for these needs. Strategies that are also interpersonal and include multiple interventions have been shown to help sustain behavior change. While large-scale media campaigns have kept messages public and visible, the effect of these campaigns on behavior change must be more thoroughly evaluated. Evaluations must assess effects on individual and group behavior change. Both interpersonal interventions and media campaigns should continue to be included in prevention/education efforts, if shown to be effective. Service providers must work to provide clear and consistent messages in all prevention/education efforts.

Maintenance of safer sexual behavior is also a critical prevention issue. San Francisco faces a complex set of issues in furthering prevention efforts and access to services for HIV-positive and HIV-negative populations. Their respective sets of needs must receive attention. Many HIV-negative gay men feel disconnected from a community they see to be defined by HIV/AIDS. Therefore, some HIV-negative gay men believe there is some incentive for them to become infected in order to gain access to perceived community support, putting them increasingly at risk for HIV infection. Along with addressing the

mental health issues of HIV-negative gay men attempting to remain negative, the additional issue of whether to target prevention messages at HIV-positive and/or HIV-negative populations must be investigated.

The Joint Task Force notes that many prevention/education recommendations outlined in the *1990 Mayor's Call to Action* are still timely and have not yet been implemented. These recommendations need to be addressed. The Joint Task Force also supports the recent *Draft Plan* created by the HIV Prevention Planning Council (HPPC) and its ongoing efforts to define and develop prevention/education strategies. Because of the comprehensive nature of this work, the Joint Task Force did not extensively review the prevention/education efforts in San Francisco. We encourage the City and County of San Francisco to support and implement the HPPC recommendations. In addition to the recommendations outlined in the above reports, the Joint Task Force adds the following:

RECOMMENDATIONS:

- Expand prevention/education efforts (including condom distribution) in jails, prisons, schools and youth-focused environments outside of school settings;
- Support existing needle exchange programs, expand current resources, and lobby in Sacramento and Washington for legalization of needle exchange;
- Link substance abuse treatment and non-IDU substance use issues with HIV prevention/education services;
- Link mental health services with HIV prevention/education services;
- Formulate a consistent, clear message for use by all San Francisco service providers concerning unprotected oral sex for both men and women;
- Pursue innovative technology for the prevention of oral-vaginal HIV transmission;
- Address sexual behavior modification in prevention strategies targeting primarily those who engage in injection drug use and other substance abuse activity;
- Address issues specific to young gay men and to older gay men in prevention efforts;
- Address issues of sexual violence, partner abuse and economic empowerment, particularly with regard to women, in prevention efforts; and
- Support continued availability of anonymous HIV-antibody testing and counseling; ensure that counseling is an integral part of *all* HIV-antibody testing.

V. SERVICE DELIVERY

The City and County of San Francisco needs a comprehensive plan that will ensure a full response to gaps in care, quality of service and access to services for every community affected by HIV. All services must be provided in a sensitive and culturally competent manner, ensuring that staff reflect the populations being served and that all agencies receive sensitivity training on issues of culture, race, ethnicity, class, gender, sexual orientation, immigrant status, language, religion and age in service delivery and treatment strategies. Service providers must also pay attention to concerns regarding substance abuse, mental health and physical ability.

All populations must have access to *all* services. Services must be available to people at all points on the continuum of HIV-infection. Both population-specific and general service providers must address the issues of populations whose needs are not currently being met, including the HIV-negative population. Service delivery strategies should include peer-based outreach and education, along with focused planning to meet the needs of underserved populations. Not only is peer-based service delivery effective, but service providers can – and should – increase the proportion of people with HIV in service delivery by expanding job training opportunities. Expanding services to underserved populations requires the utilization of non-HIV related community facilities such as churches, recreational facilities and schools and requires specific outreach, education and information in jails and prisons. Pediatric HIV services should be linked with other children's services. The needs of people with late- and end-stage AIDS should be addressed through an established link between acute care facilities and other necessary services, ensured accessibility for people who are non-ambulatory and increased hospice and other appropriate services.

In order to address the comprehensive spectrum of women's needs, HIV programs for women should recognize the impact that issues like sexual abuse, battering, eating disorders, poverty, sexism, substance abuse and mental health have on women's physical and mental well-being. The psychological and behavioral impact of HIV-infection when related to sexual abuse and violence must also be addressed.

Youth programs should incorporate HIV into other pressing issues for youth such as substance use, sexual abuse, pregnancy, employment, school and personal relationships. In conjunction with peer-based outreach, this approach will encourage utilization of expanded services, including HIV-antibody testing, and build the necessary community of support among youth affected by HIV.

In responding to stated needs, HIV planning bodies must not look solely at increasing the quantity of services, but rather, determine if needs could better be addressed by increasing the quality or accessibility of these services. Service providers must also expand publicity and outreach to underserved populations, and explore ways to increase utilization of services.

In the Joint Task Force's review of previous documents, testimony given at public forums, focus groups and interviews with representatives of citywide HIV/AIDS policy and advisory bodies, service providers, caregivers and people with HIV, specific gaps in quantity, quality or accessibility of service were identified in each of the following areas:

- Benefits/Financial/Money Management Assistance
- Board and Care Services
- Buddy/Companion Services
- Case Management
- Day and Respite Care
- Dental Services
- Direct Emergency Assistance
- Eye Care Services
- Food/Nutritional Support
- Foster Care/Adoption/Guardianship Assistance
- Home Health Care
- Hospice Care
- Job Training Services
- Legal Services
- Transportation
- Vouchers

Certain concerns and recommendations were repeated by more than one source and some emerged as new issues to be addressed. Many items raised in previous reports still have not received adequate attention. Our recommendations stem from an analysis of all these concerns and from an attempt to highlight outstanding issues.

In addition to concerns about the quantity, quality or accessibility of the above services, particular issues were repeatedly raised in the areas of primary medical care, mental health services, substance abuse treatment and housing. Although the exploration of these four major areas and the accompanying recommendations are neither the result of an all-inclusive needs assessment nor an exhaustive catalogue of recommendations, the Joint Task Force thought it was important that these areas be explicitly highlighted. Both overarching and specific recommendations within each of these areas are addressed below, with recommendations present both in the text and in the subsequent lists entitled "Further Recommendations." Neither the topics nor the recommendations are rank-ordered.

PRIMARY MEDICAL CARE

Primary medical care providers have taken significant steps toward addressing the ever-expanding numbers of people with HIV/AIDS. However, San Francisco must continue to commit to providing comprehensive, high quality medical services for *all* people with HIV/AIDS, including uninsured and indigent populations. We appreciate the continued leadership San Francisco General Hospital has shown in these areas. We also support increased attention to the provision of comprehensive, high quality medical care to incarcerated populations. As researchers and medical care providers explore new treatment methods, the concept and availability of medical care must be expanded to include a broad range of treatments, whether western medical models, holistic therapies, acupuncture or other traditions of medical practice. Information on all these services must be provided through medical outreach efforts. Again, the needs of specific populations must be addressed in any approach to the delivery of primary health care, recognizing that HIV/AIDS does not manifest the same way in all individuals, and that culture, ethnicity, class, gender, sexual orientation, immigration status, language, religion and age all affect how and where an individual will seek health services.

FURTHER RECOMMENDATIONS:

- Analyze current standards of practice for gender bias in diagnosis;
- Provide low cost HIV/AIDS treatment options;
- Research, treat and provide education around women-specific manifestations of HIV/AIDS;
- Protect the availability of in-patient, discharge and out-patient case management in primary care facilities;
- Expand attendant and skilled nursing care for home-based health care; and
- Expand medical services for transgendered people dealing with pre-/post-operative issues as they relate to HIV/AIDS.

MENTAL HEALTH SERVICES

Mental health services must be responsive to the community impact of extensive loss due to AIDS, to individual emotional and psychological support needs, and to diagnosed mental health conditions such as depression or suicidal behavior. Mental health services that are appropriate with regard to issues of culture, race, ethnicity, class, gender, sexual orientation, immigrant status, language, religion and age must be expanded to respond to the issues noted above.

The HIV epidemic has had a particularly devastating effect on San Francisco, especially within the various gay/bisexual male communities. Investigation must be conducted into how these communities cope with long-term loss due to AIDS, how overall community well-being impacts individual seroconversion, and how the focus on short-term versus long-term strategies of HIV care affects the mental health of individuals and the community. Low self-esteem, hopelessness and lack of empowerment on the part of individuals and communities may affect behaviors and therefore must be addressed.

Engaging with communities that have created innovative community coping mechanisms in the face of widespread oppression and isolation is encouraged in order to develop new "community survival" models for the gay/bisexual male communities.

Mental health counseling must be available to all populations. Support groups geared toward particular populations are important to address population-specific needs, as well as to foster community building and reduce isolation. Sustained emotional support is particularly important for people with late- and end-stage AIDS.

The complex issues surrounding the interconnection of substance abuse, mental health and HIV must also be addressed by mental health service providers.

FURTHER RECOMMENDATIONS:

- Increase grief and bereavement services;
- Integrate spiritual counseling and pastoral care into counseling/support models and community building;
- Develop more women-specific support groups;
- Establish programs that address the emotional and psychological issues of AIDS caregivers;
- Develop youth-specific counseling programs using peer models and addressing issues of self-esteem;
- Expand programs for people with multiple diagnoses (people affected by some combination of substance abuse, mental health, AIDS Dementia Complex, AIDS);
- Increase mental health programs for homeless people;
- Increase psychosocial services for transgendered people dealing with pre-/post-operative issues as they relate to HIV/AIDS;
- Staff substance abuse agencies with a psychiatrist or therapist to provide appropriate care for those needing mental health services; and
- Provide counseling around self-esteem building, negotiation skills and post-traumatic stress for survivors of rape, sexual abuse and/or physical abuse, and explore the causal effect of low self-esteem and post-traumatic stress on unsafe behaviors.

SUBSTANCE ABUSE TREATMENT

The interconnection of substance abuse and HIV affects nearly every aspect of HIV service provision. Treatment availability "on demand" was outlined as a goal in the *1990 Mayor's Call to Action*. Today, it has yet to be realized. The interconnection of substance abuse with HIV and other conditions warrants increased attention, including an expansion in comprehensive, supportive counseling and other services. Substance abuse relapse among people with HIV must also be addressed. Addressing these issues requires an increase in all substance abuse services, including substance abuse prevention/education efforts, and must include a review of program requirements in an effort to make treatment programs more accessible.

FURTHER RECOMMENDATIONS:

- Increase access to detox and residential treatment programs for homeless people;
- Expand methadone maintenance programs for people with HIV and increase funding for free or low cost methadone treatment, with particular attention to slots for people who are between GA and SSA benefits;
- Integrate HIV prevention/education into drug and alcohol treatment programs;
- Expand programs for people with multiple diagnoses;
- Target treatment slots for the transgendered population;
- Expand treatment slots for women to live with their children while abstaining from substance abuse, and for women without children;
- Provide a continuum of care for incarcerated people to receive substance abuse and HIV-related treatment;
- Extend HIV services to people who choose not to enroll in substance abuse programs, with increased recognition of models that emphasize harm reduction, including needle exchange; and
- Increase awareness of linkages between physical and/or sexual abuse and substance abuse issues.

HOUSING

Housing issues are a growing concern to more and more people living with HIV, especially those with AIDS. The lack of affordable, safe, supportive housing in San Francisco severely challenges the ability of many people with HIV/AIDS to stabilize their lives. Without a safe living space, a person's efforts to secure health care and social services will often take second priority to her or his need to find shelter. Delivering services to people who are homeless is also complicated by the fact that they often lack a reliable contact address or telephone number. This impedes service providers' efforts to disseminate and collect information and provide a continuum of care. In order to provide safe and supportive housing options for people with HIV/AIDS who are currently homeless and to prevent currently housed people with HIV/AIDS from ending up on the street, the Joint Task Force recommends expanding HIV housing services. These housing services must include short-term, emergency and permanent housing and must be linked with mental health care and other social services. Additionally, there is a need to target more housing for people with HIV/AIDS living with their families, along with housing for people with HIV/AIDS who are actively using substances, who have relapsed from recovery or who are unwilling to enter substance abuse treatment programs.

The Joint Task Force recommends the exploration of an "AIDS Housing Development Corporation" (AHDC) to take responsibility for the purchase, renovation and property management of buildings purchased with Housing Opportunities for People with AIDS (HOPWA) and other housing funds. Should an AHDC be established, it must work together with HIV housing service providers and residents of HIV housing units in meeting the full range of housing needs for people with HIV/AIDS in San Francisco.

The efforts of existing low-income housing development corporations to provide appropriate housing for people with HIV/AIDS should also be supported and encouraged. Creative models should include converting housing that is currently leased by nonprofit agencies into owned property for long-term availability and affordability, along with developing "mixed projects" which set aside units in standard affordable housing developments for people with HIV/AIDS. A model of evaluation for HIV housing development and HIV housing services must also be established.

The San Francisco Five-Year Housing Plan prepared by the San Francisco Department of Public Health's AIDS Office sets out specific recommendations for the development of a comprehensive plan for HIV housing service provision. These recommendations must be implemented. The plan focuses on creating an equitable, accessible system of coordination between housing services and other service areas, as well as centralizing access to housing resources, information and placement services. This proposed system is currently being designed and implemented; an evaluation of the program in twelve to eighteen months should ensure that it is fulfilling stated goals.

FURTHER RECOMMENDATIONS:

- Provide rental assistance for people who are homeless or at risk of becoming homeless ("tenant-based" rental assistance and subsidies);
- Encourage all housing providers to accommodate people with AIDS Dementia Complex;
- Include respite care in housing development plans;
- Target housing for the transgendered population;
- Provide more housing slots for people with multiple diagnoses;
- Expand the availability of hospice care in all residential settings; and
- Increase flexibility of eligibility criteria for women's beds in transitional housing in order to fill women's slots.

VI. COORDINATED CONTINUUM OF CARE

With one in every twenty-six persons in San Francisco estimated to be HIV-infected, HIV service providers are challenged to keep pace with the demands of the epidemic. Without effective and comprehensive coordination of the HIV service delivery system, simply increasing the quantity, quality and accessibility of services compromises a complete response. What is needed is a client-centered and coordinated system of services that enables community collaboration.

This urgent need for coordination and reorganization stems from the continued difficulties people have accessing services that should be easily available. Throughout its work, the Joint Task Force heard time and again how difficult it is for newly diagnosed individuals – particularly those most disenfranchised – to sort through the "San Francisco system." While some progress has been made in improving this access, the sheer size, complexity, wide decentralization and disorganization of the HIV service system make navigating the system a continuing challenge to both service providers and far too many potential clients. People affected by HIV should not have to access the system alone in order to receive continuity of care.

This section of ***A Second Decade Response to HIV/AIDS in San Francisco*** is devoted to a recommended reorganization of HIV service delivery in San Francisco, based on the concerns expressed in previous sections. As such, our recommendations fall generally into the six sub-headings of this section.

Any recommendation for reorganizing HIV service delivery must take into account both that people with HIV/AIDS are living longer, and the undeniable fact that systems of managed care and consolidation are now being planned and preliminarily implemented in San Francisco. Regardless of our concerns about these systems, or possibly *because* of our concerns, HIV policy makers and advisors must be a part of the planning and implementation of managed care and consolidation. HIV service provision must be conceived within the perspective of a broad plan for all health and social service delivery in San Francisco, and must be implemented through a coordinated, comprehensive, community-wide effort that ensures client confidentiality. Quality of care and access to care must be as important as the focus on maximizing resources and saving costs.

In order to respond to the needs of all people affected by HIV, this systemwide coordination of services must preserve the integrity of community-based efforts. The system must link existing services with community networks, encourage increased communication and information sharing between service providers, and develop new

programs to satisfy unmet needs in a culturally competent manner. Population-specific community groups have the interest, commitment, and experiential foundation to address the impact of HIV on their respective communities. A community-driven approach such as this would also embrace spirituality issues and overall community well-being in responding to the epidemic.

In the coordination of services, it is imperative to address both emerging populations with HIV (such as homeless people and women) and existing populations struggling to continue meeting their needs (such as gay men). People of color, women, youth, substance users, people with multiple diagnoses, homeless people, people who are incarcerated, transgendered people, HIV-positive gay men and HIV-negative gay men should all be specifically targeted populations. Caregivers, families and service providers should also be targeted. Services to caregivers and families should not stop when the infected individual dies. Incorporating all of these populations in the scope of service delivery is necessary to a comprehensive response to the HIV epidemic.

A centralized database with strong confidentiality protections would allow intake to be conducted at any site, including service centers providing multiple services. As needed, intake information could be accessed by service providers at agencies utilized by the individual, thus preventing the endless repetition of data gathering and enabling better service to clients.

To ensure the most effective response of such a coordinated system, the City and County of San Francisco must:

- create a definition for "standard of care;" and
- develop appropriate policies and procedures to ensure that the proper standard of care is maintained.

While there are limitations on standardizing an evaluation process with regard to maintenance of standard of care when specific populations are targeted with specific service methods, efforts should be made to evaluate parallel criteria.

Therefore, in reorganizing the delivery of services into a more comprehensive, effective system, the following components should be among those included:

- coordinated intake and evaluation, with comprehensive information and referral;
- centralized case management;
- job description/pay scale standardization;
- centralized database with strong confidentiality protections;
- centralized service delivery with neighborhood/target population satellites; and
- coordinated volunteer recruitment, referral, training and retention.

COORDINATED INTAKE AND EVALUATION; INFORMATION AND REFERRAL

Currently, many HIV service providers see people who seek services but have never been oriented to the HIV service system as a whole. Thus, service providers are distracted from their specific service area as they attempt to guide the client through the full

service system with greater or lesser degrees of success. The creation of a coordinated intake, evaluation and information referral system would allow individuals an initial point of intake, an overall understanding of the entire system of resources, and a referral to the specific services they wish to access. Through a database system with confidentiality protections, this intake process could be accessed by any HIV service agency. Simple, easily understood information could be accessible to people with HIV through a main telephone line staffed by HIV-sensitive providers and through drop-in intake at community agencies or service centers.

Initial client contact would be conducted by a client advocate who would check a centralized database for an eligibility/demographic profile of the client and, if one was not established, conduct the initial entry. The client advocate would also verify diagnosis and eligibility and evaluate the needs of the client. Utilizing the information and referral database, the client advocate could offer resources and assist the client with questions regarding available services. The role of the client advocate must include assistance with emergency services including housing, food, medical and psychiatric services. A client in need of ongoing or more comprehensive assistance could arrange an appointment with a case manager through the client advocate.

CENTRALIZED CASE MANAGEMENT

Currently, there is little case management available for the great majority of people with HIV in San Francisco, leaving clients to "manage" their own disease by finding appropriate services. In a coordinated service system, client advocates could refer clients to case managers, who would both facilitate access to the medical care system and manage client care within the HIV social service delivery system. Easy access to timely and comprehensive case management services is particularly important for people with late- and end-stage AIDS.

The role of case managers would be to act as facilitators for people affected by HIV to access the services they need. Case managers would provide substantive evaluation of the client's condition in order to establish her/his medical, financial and social resources and create a case plan to stabilize the client's life conditions.

While San Francisco supports a model of service delivery that emphasizes the self-empowerment of clients, it should be noted that, unfortunately, the general direction of health care reform at both the federal and state levels is toward a new managed care model of health service delivery. This means that the case manager may represent the "gatekeeper" for services. There will be an emerging need for a case management system that oversees medical service delivery, including primary care, in-home nursing and attendant care for clients. Case management for HIV *social services* may represent a parallel system that could potentially be linked to a *medical* case management system, although in the HIV social services model, the gatekeeper would *facilitate*, rather than limit, access to the system of care.

JOB DESCRIPTION/PAY SCALE STANDARDIZATION

The reorganization and development of roles in the HIV service system necessitate systemwide expectations of standards and performance. This requires standardization of job descriptions and pay scales, along with a systemwide definition of "client advocate" and "case manager." These, along with a standardized assessment tool, should be created and monitored by the AIDS Office of the Department of Public Health. Given the variation in funding levels of private versus public agencies and the funding disparities among private, community-based organizations, this task will be complicated. Sensitivity and extensive thought must be given to the differing needs within agencies for particular kinds of case management, depending on the client base. Thus, unions representing HIV service providers and health care workers, along with organizational development and diversity trainers should be consulted for assistance in the development of any plans for standardization. The overall goal of standardization must be a uniformly high standard of HIV care and the ability of community-based organizations to compete for qualified staff to ensure that standard of care.

CENTRALIZED DATABASE; CONFIDENTIALITY PROTECTIONS

The development of an extremely user-friendly, electronically linked, confidential, computerized database for HIV service provision that is accessible to all agencies will create a crucial foundation for the improvement of service delivery in San Francisco. It is absolutely critical that the database utilize a sophisticated set of passwords and access restrictions in order to protect the integrity of information and client confidentiality. Confidentiality of HIV-related information is a *primary* concern that must supersede convenience to service providers when the two considerations conflict. Consent forms allowing information to be shared with any agencies where the client is requesting services would need to be signed and kept on file. Funding must be made available for all community-based agencies to be trained in this new system and for the computer linkage to be installed throughout the network of service providers.

The database should be constructed with distinct individual modules that have *separate access restrictions*, but it should also have the capacity for linked modules when appropriate. Five such suggested modules are a) information and referral, b) eligibility and demographics, c) case management, d) service utilization, and e) appointment scheduling.

Given adequate funding and careful planning, a database of this type could both preserve confidentiality and improve HIV service delivery by allowing the "frontline" personnel in service provision – client advocates and case managers – to access the most accurate information on services available to clients. Centralized intake/eligibility documentation would also let case managers focus on the delivery of services, rather than on the collection and recollection of reporting information. Again, access restrictions would ensure confidentiality protections, with personnel allowed access only to information as needed.

A database would improve the ease and accuracy of collecting contract compliance reporting information and also enable a high level of service to be provided at a variety of locations, with the flexibility to target specific populations with culturally appropriate models. This would allow for home-based intake, referral and simple access to a network of services for people with disabilities. Reliable and easily-accessed information regarding treatment and service options, particularly clinical trials, could be provided. Funding should be made available for statistical analysis to be performed on behalf of the City and County of San Francisco, using the data gathered through this system. This contracted service could provide critically important information regarding the HIV epidemic in San Francisco to local, state and federal policy makers and would allow ongoing evaluation of both service and prevention/education efforts.

CENTRALIZED SERVICE DELIVERY;
NEIGHBORHOOD/TARGET POPULATION SATELLITES

The Joint Task Force recommends exploring the concept of centralized service delivery through the development of a main service center and neighborhood/target population satellite centers. Multiple services would be available at each of these centers, saving clients the time, money and energy now spent going to many different locations in order to access care. These centers would provide services related to housing, emotional and practical support, financial assistance and money management, peer support, mental health, substance abuse, transportation and legal assistance and referrals. The centers would house as many service providers as possible who are willing to locate their services or offer office hours at such a center. Although some services, such as primary care, residential services, and food delivery services may not be well suited to on-site provision at service delivery centers, access to such services would still be connected to the centralized intake and case management systems. Every service center should be able to accommodate people in a variety of physical conditions, with appropriate staff and security in place to respond to emergency conditions.

We are *not* suggesting the development of another Center for Positive Care (CPC), an HIV early intervention resource center developed in San Francisco in 1991 as a collaborative effort among seventeen social services providing HIV services in one location. We believe the work done in the creation of the CPC must be critically reviewed to determine the problems encountered and to help devise solutions that avoid these difficulties. This analysis must inform current efforts to develop a comprehensive, coordinated system.

A culturally competent service delivery plan must utilize *existing agencies* to continue and expand community-based service provision, particularly for targeted populations who have difficulty accessing services through the mainstream systems. These designated neighborhood/target population satellites should be culturally appropriate for the populations they serve; they should be managed and staffed by people who are experienced in working with those populations; and they should be located in neighborhoods that are appropriate for those populations. These satellites would all

access the intake and referral system, case management system and common database through a modem connection to the main service center. A consistent standard of care for these systems would be established through centralized training, evaluation and quality assurance reporting. Service provision at these neighborhood/target population satellites could also be linked to anonymous HIV-antibody testing site services, so that a direct and immediate service response is available to those testing HIV-positive.

Service delivery sites must have reception personnel who are sensitive to issues of culture, ethnicity, class, gender, sexual orientation, immigrant status, language, religion and age, and must provide services appropriate to the populations served. Access for people with disabilities must be assessed before sites are secured, with acknowledgment of the Americans with Disabilities Act (ADA) regulations. Agencies should include consideration for mobility difficulties, visual impairment and environmental illnesses, taking into account the needs of both staff and clients. Sites should have TDD access and full staff training in services to the deaf and hearing impaired community. In instances in which the service delivery site's client base is insufficient to permit the hiring of *specialized* client advocates and case managers, these staff should be obtained by contract from community-based agencies. These contractors, like the permanent site staff, must observe confidentiality provisions, reflect the populations served and be trained in HIV issues.

COORDINATED VOLUNTEER RECRUITMENT, REFERRAL, TRAINING, RETENTION

In many critical ways, San Francisco's service delivery system is dependent on volunteers. A *coordinated* volunteer system would significantly improve the HIV service system's ability to utilize volunteers for service delivery. Currently, each service provider competes for volunteers, but few providers have the resources to recruit, train, supervise and appreciate their volunteers sufficiently to sustain and retain them. A centralized volunteer recruitment, referral, training and retention system should be created and would best be developed by an agency with extensive volunteer utilization needs and expertise in the diverse volunteer dynamics in working with, for example, people of color communities, transgendered communities and people with a history of substance abuse. Models for culturally competent volunteer systems should be drawn upon in creating a new centralized volunteer system for the San Francisco HIV service system.

VII. CONCLUSION

A Second Decade Response to HIV/AIDS in San Francisco is necessary at this stage of the epidemic. Tremendous work has been carried out during the last thirteen years and we honor the organizers, the advocates and those who have gone before us in meeting the challenge that HIV/AIDS has presented to us all. We have experienced enormous loss, along with individual and community-wide trauma, and somehow in the face of that reality, we must find the inner strength, the financial resources and the community will to acknowledge that our current model of service provision is no longer adequate. Now, in this second decade, it is time to develop *new* strategies and *different* structures in order to better provide appropriate service to people infected and affected by HIV. It is time to assess the variety of needs among our many communities and the subsequent demands placed on service providers.

The issues are complex, the needs are great, the political struggles unfortunate and the funding less than ideal. It will take all of us working in unison to create a centrally planned, coordinated system that offers new levels of high quality, accessible HIV service to all populations in need. We challenge ourselves and each other, along with service providers, policy advisors and the City and County of San Francisco to make this ***Second Decade Response*** a reality.

APPENDIX A

ORDINANCE 75-93

FILE NO. 174-93-1 ORDINANCE NO. 75-93

[Joint Task Force on the HIV Epidemic]

AMENDING CHAPTER 5 OF THE SAN FRANCISCO ADMINISTRATIVE CODE BY ADDING ARTICLE XVII, SECTIONS 5.160 - 5.165 THERETO, CREATING A JOINT TASK FORCE ON THE HIV EPIDEMIC TO ADVISE THE BOARD OF SUPERVISORS AND THE MAYOR ON LEGISLATION AND POLICY RELATED TO THE CITY'S HIV POLICIES AND PROGRAMS.

NOTE: All sections are new.

Be it ordained by the People of the City and County of San Francisco:

Section 1. FINDINGS. It was over a decade ago when the first gay men became ill from strange and exotic ailments. In those early years, AIDS was viewed as a budget problem, a political problem, a public relations problem, or a homosexual problem. Now it is recognized for what it is -- an epidemic, a disaster. Over 10,000 San Franciscans have died from AIDS. Another 28,000 City residents are infected with HIV and 9,000 of them have AIDS under the newly revised official definition of the disease. Statistics show that nearly 45% of the City's gay and bisexual men are infected. HIV infection and AIDS are increasing at alarming rates among women, communities of color, and gay and bisexual youth. Unless a treatment and care is provided, the relentless progression of AIDS may eventually kill all those infected.

San Francisco renews its commitment to fight the scourge of

AIDS and HIV, not just by maintaining current effort, but by focusing more than ever on developing and funding gender and culturally and linguistically appropriate prevention, education, intervention and treatment programs. The City also renews its commitment to provide social, health care and other essential services to people with AIDS and HIV, and to protect the rights of these same people to be free from discrimination.

Section 2. The San Francisco Administrative Code is hereby amended by adding Article XVII, Sections 5.160-5.163 to Chapter 5, to read as follows:

ARTICLE XVII

JOINT TASK FORCE ON THE HIV EPIDEMIC

SEC. 5.160. JOINT TASK FORCE ON THE HIV EPIDEMIC ESTABLISHED. (a) There is hereby established a Joint Task Force on the HIV Epidemic. This Task Force shall be advisory to the Board of Supervisors and the Mayor.

(b) There shall be twenty-five (25) voting members to the Task Force, who shall be appointed as follows:

1. The Mayor, or his or her designee, shall serve as a member.

2. The President of the Board of Supervisors, or her or his designee, shall serve as a member.

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3. The Director of Health, or his or her designee, shall serve as a member.

4. The County Health Officer, or her or his designee, shall serve as a member.

5. The Director of the AIDS Office of the Department of Public Health, or his or her designee, shall serve as a member.

6. Eleven members shall be appointed by the Board of Supervisors.

7. Eight (8) members shall be appointed by the Mayor.

8. The Health Commission shall appoint one (1) member to the Task Force.

(c) The members of the Task Force shall be broadly representative of the ethnic, racial, gender, age and sexual orientation diversity of the City and County. All members of the Task Force shall be residents of the City and County of San Francisco, in accordance with Section 8.104 of the Charter. In making appointments to the Task Force the appointing authorities shall appoint persons from varying backgrounds who have demonstrated abilities, vision, or experience in dealing with the AIDS crisis. The appointments shall include representatives from existing AIDS advisory groups and providers of various public services, including, but not limited to, direct medical care, early intervention, prevention, mental health care, social services, legal services, health planning services, and housing. Special outreach and consideration shall be given to persons with AIDS/HIV, people of color, lesbians, gays, bisexuals, injection drug users, women, and community activists and organizers.

(d) The Mayor and the Health Commission are to make their appointments and advise the Board of Supervisors of same within fifteen (15) days after the date this ordinance takes effect. The Board of Supervisors shall make its appointments to this Task Force within 30 days from the date this ordinance takes effect.

SEC. 5.161. ORGANIZATION. (a) In the event a vacancy occurs, a successor shall be appointed to fill the vacancy consistent with the process and requirements to appoint the previous appointee.

(b) The initial meeting of the Task Force shall be called within 20 days from the day the Board of Supervisors completes its initial appointments.

(c) The Task Force shall adhere to Robert's Rules of Order. The Task Force shall also conduct its business consistent with the provisions of the Ralph M. Brown Act, which governs certain procedures related to the conduct of meetings by public bodies.

(d) A quorum for the conduct of business by the Task Force shall be the presence of at least thirteen of the members of the Task Force.

(e) Any voting member who misses three regularly scheduled meetings of the Task Force in any 12-month period without obtaining the express approval of at least 51 percent of the members of the Task Force at a regularly scheduled meeting shall be deemed to have resigned from the Task Force.

(f) The Mayor shall designate the first Chair of the Task Force, and the President of the Board of Supervisors shall designate the first Vice-Chair of the Task Force. For each successive year the authority to designate the Chair and Vice-Chair shall rotate between the Mayor and the President of the Board.

SEC. 5.162. POWERS AND DUTIES. The Task Force shall have the duty to:

a Prepare and submit to the Board of Supervisors and the Mayor an annual report on the state of the HIV epidemic, which shall include a review and evaluation of the services and programs in place to respond to the epidemic, any outstanding needs, and recommendations and plans as to a program for responding to the epidemic.

b Assist in coordinating information, activities and goals among existing City and County AIDS/HIV advisory and planning groups.

c Assist in improving the delivery of, and efficiency in the provision of, medical services, including HIV early intervention and primary medical care, and to identify and encourage consolidation opportunities for program and administrative services.

(d) Assist the Mayor's Office in organizing official delegations to go to Washington, D. C. and Sacramento to lobby for

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federal and state monies for City AIDS services and HIV related programs, and to expand public-private partnerships to meet the growing needs of the HIV epidemic.

(e) Make progress reports on the execution of its duties to the Mayor, the Board of Supervisors and the Health Commission on a quarterly basis. At the first HIV Task Force meeting, the members shall set quarterly dates for the submission of said reports. The HIV Task Force shall submit its findings and recommendations in a final report to the Mayor, the Board of Supervisors and the Health Commission within one year from the date of its first meeting. Prior to its submission, the HIV Task Force shall conduct public hearings on the draft of the final report. The final report shall be made available to interested citizens upon request and at the City's public library.

SEC. 5.163. STAFFING FOR THE HIV TASK FORCE. The Mayor, the Board of Supervisors and the Health Commission shall provide in-kind professional and administrative staff to the Task Force.

SEC. 5.164. COMPENSATION. Members of the Task Force shall not be compensated, nor shall they be reimbursed for expenses. The Task Force may seek funds from public and private agencies to carry out its functions. Any money received other than from the City shall be deposited with the City Treasurer.

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SEC. 5.165. TERMINATION OF TASK FORCE. The Task Force shall cease to exist one year after the date of its first meeting, unless its life is extended by legislation of the Board of Supervisors.

APPROVED AS TO FORM:

LOUISE H. RENNE, City Attorney

By: Theodore R. Lakey

Deputy City Attorney

APPENDIX B

DESCRIPTION OF CITYWIDE HIV/AIDS POLICY AND ADVISORY GROUPS

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DESCRIPTION OF CITYWIDE HIV/AIDS POLICY AND ADVISORY GROUPS

The organizations listed below were represented at the meeting of citywide HIV/AIDS policy and advisory groups hosted by the Joint Task Force at City Hall on August 31, 1994. This information was collected at that meeting and from written bylaws and other materials submitted by these groups to the Joint Task Force.

AIDS HEALTH SERVICES ADVISORY COMMITTEE:

Membership	Comprised of representatives from contractors to the Health Services Branch of the San Francisco Department of Public Health's AIDS Office.
Meetings	Meets monthly.
Purpose	Serves as a forum for discussion of issues pertinent to both contractors and the AIDS Office. Formed in 1989, convened by AIDS Office.

AIDS PREVENTION ADVISORY COMMITTEE:

Membership	Comprised of representatives from agencies that provide prevention/ education in San Francisco.
Meetings	Meets monthly.
Purpose	Provides the Prevention Services Branch of the San Francisco Department of Public Health's AIDS Office with guidance, feedback and assistance in the development and implementation of a comprehensive approach to prevention/education in San Francisco. In the process of identifying its role and relationship to the San Francisco HIV Prevention Planning Council.

CARE COUNCIL: *(see HIV Health Services Planning Council, below)*

COALITION FOR HEALTHY SEX:

Membership	Comprised of representatives from sex clubs and health, advocacy and HIV organizations who subscribe to the intent and philosophy of the Coalition for Healthy Sex. Individuals may join as non-voting members.
Meetings	Meets monthly.
Purpose	Promotes the safe operation of establishments that provide an explicitly sexual environment, and publicly frames issues that affect group or public sex in these establishments. Informal advisory and consultation relationship with the San Francisco Department of Public Health's AIDS Office.

COALITION FOR POSITIVE FAMILIES WITH CHILDREN:

Membership Comprised of individuals and service providers engaged in providing services for HIV and AIDS affected families with children.

Meetings Meets monthly.

Purpose Represents and advocates for families infected and affected by HIV and AIDS in San Francisco and the Bay Area through the cooperation and collaboration of service providers. Has initiated a formal link with the San Francisco Department of Public Health's AIDS Office. Formed in 1992.

HIV HEALTH SERVICES PLANNING COUNCIL (A.K.A. CARE COUNCIL, RYAN WHITE COUNCIL) [THIS BODY IS LEGISLATIVELY MANDATED]:

Membership Comprised of members appointed by the Mayor of San Francisco; members include representatives of the following groups: affected communities, including individuals with HIV disease; health care providers; community-based organizations; AIDS service organizations; social service providers; mental health providers; local public health agencies; hospital and health care planning agencies; non-elected community leaders; State government; grantees of early intervention programs; the lead agency of any Health Resource Services Administration adult and pediatric HIV-related care demonstration project operating in the area; hemophiliacs; people who are incarcerated; homeless people; people with physical disabilities, including visual or hearing impairment; and advocates for new immigrants and undocumented persons. There are presently 24 appointed members.

Meetings Meets twice monthly.

Purpose Establishes priorities for the allocation of CARE Act funds within San Francisco. Has formal and direct policy recommending, planning, advisory and consultation relationship with the San Francisco Department of Public Health's AIDS Office. Recently submitted its continuation grant application for federal funding, and published *Voices of Experience*, a client survey on how to make HIV services in San Francisco more "user-friendly." The San Francisco CARE Council was mandated by the federal government when it enacted CARE legislation (Titles I and II) in 1990.

HIV PREVENTION PLANNING COUNCIL [THIS BODY IS LEGISLATIVELY MANDATED]:

Membership Comprised of members appointed by the Director of the San Francisco Department of Public Health's AIDS Office in consultation with the Chief of the Prevention Services Branch of the AIDS Office and the chairs of the AIDS Prevention Advisory Committee, People of Color Advisory Committee and the CARE Council; members include representatives from the following groups: The San Francisco Department of Public Health's AIDS Office and Community Health Services Division; the San Francisco Unified School District; the San Francisco Division of Mental Health, Substance Abuse and Forensics; the State Office of AIDS; experts in

epidemiology, behavioral and social sciences, evaluation, research and health planning; non-governmental/community organizations providing HIV prevention and related services; and affected communities. There are 37 appointed members; qualified individuals may participate in subcommittees in a non-voting capacity.

Meetings — Meets twice monthly.

Purpose — Establishes priority HIV prevention needs by target populations and proposes high priority strategies and interventions. Functions as the central coordinating body for all HIV prevention advisory groups previously convened. Has direct planning, policy recommending, advisory and consultation relationship with the San Francisco Department of Public Health's AIDS Office. Recently submitted its draft report of the City's proposed comprehensive HIV prevention plan to the federal Centers for Disease Control and Prevention (CDC). The HPPC was mandated by the CDC in February 1994 as part of its community prevention planning strategy, although the HPPC currently has no fiscal oversight of Centers for Disease Control prevention funds. The CDC also mandated the creation of the California Community Planning Working Group, a statewide body with a similar charge to that of the HPPC. In this report, we refer only to the work of the San Francisco group.

HIV YOUTH ADVISORY COMMITTEE (A.K.A. HIV YOUTH TASK FORCE):

Membership — Comprised of members appointed by the President of the Board of Supervisors; members include at least seven young adults living with HIV or AIDS. Fifteen total members.

Meetings — Meets twice monthly.

Purpose — Reviews the structure of services for HIV infected and affected youth, ages 12 to 25, in San Francisco, and makes recommendations for improvements in services. Issues a final report at the close of tenure. Direct relationship with AIDS Office (AIDS Office personnel serve as staff for the Committee). Formed in 1993 by Board of Supervisors; tenure expires in December 1994.

PEOPLE OF COLOR ADVISORY COMMITTEE:

Membership — Comprised of representatives from agencies that provide HIV/AIDS services to communities of color in San Francisco.

Meetings — Meets monthly.

Purpose — Provides guidance, feedback and assistance in the development and implementation of HIV/AIDS policies, programs and services in the AIDS Office that are culturally and linguistically sensitive, and addresses other issues pertinent to HIV/AIDS services and to the diverse communities of color in San Francisco. Ensures that existing agencies include specific programs for communities of color in their planning and funding initiatives. Has direct and formal link with the AIDS Office. Member groups of the

Committee, in collaboration with the San Francisco Department of Public Health's AIDS Office, published the report, *People of Color and HIV/AIDS: Planning for Treatment and Services in San Francisco.*

SAN FRANCISCO COMMUNITY CLINIC CONSORTIUM:

Membership An independent, nonprofit partnership of ten community health centers.

Meetings Is a standing agency; no meetings.

Purpose Promotes access to high quality and affordable, comprehensive and culturally-sensitive health care services for all people in San Francisco. The SFCCC advocates for changes in health care policy and health services to benefit the medically underserved, disenfranchised, and under/uninsured. Formal relationship with AIDS Office as a contractor; represented member on the CARE Council.

SAN FRANCISCO HEALTH COMMISSION:

Membership Comprised of Health Commissioners appointed by the Mayor. Commissioners have three-year tenure.

Meetings Meets twice monthly.

Purpose The governing body of the San Francisco Department of Public Health. Sets policies pertaining to the preservation, promotion, and protection of the lives, health and mental health of the inhabitants of San Francisco. Appoints the Director of Public Health. Establishes policies governing the various divisions and hospitals of the Department of Public Health. Establishes and makes appointments to advisory committees.

SAN FRANCISCO HIV CONTRACTORS ASSOCIATION:

Membership Open to any incorporated nonprofit agency that has a contract with the San Francisco Department of Public Health's AIDS Office.

Meetings Meets monthly.

Purpose Improves and upgrades the provision of HIV services to clients by increasing coordination and cooperation among HIV contractors and the AIDS Office. Has advocacy relationship with AIDS Office. Formed in 1993.

The following groups were not represented at the Joint Task Force's citywide HIV/AIDS policy and advisory group meeting. However, because of the increased need for HIV-related housing services and because San Francisco is receiving increased funds to develop and provide HIV housing services, it is important to note the existence of these citywide HIV/AIDS housing policy and advisory groups. Therefore, the Joint Task Force has included them in this listing.

HOUSING OPPORTUNITIES FOR PEOPLE WITH AIDS (HOPWA) LOAN COMMITTEE [THIS BODY IS LEGISLATIVELY MANDATED]:

Membership Comprised of representatives from the following groups: the Mayor's Office, the CARE Council, the San Francisco Redevelopment Agency and the San Francisco Department of Public Health's AIDS Office.

Meetings Regular meetings during HOPWA funding cycles.

Purpose Responsible for final approval of all HOPWA allocations. HOPWA funding originates at the federal Department of Housing and Urban Development (HUD) and is administered locally by the San Francisco Redevelopment Agency. Mandated by the federal AIDS Housing Opportunities Act.

HIV/AIDS HOUSING NETWORK:

Membership Comprised of 150 San Francisco HIV Housing Providers, advocates and residents.

Meetings Meets monthly.

Purpose Provides consultation on HIV housing issues. Exchanges program information, technical assistance and funding notification among members.

APPENDIX C

LINKAGES BETWEEN CITYWIDE HIV/AIDS POLICY AND ADVISORY GROUPS

APPENDIX C
LINKAGES BETWEEN CITYWIDE HIV/AIDS POLICY AND ADVISORY GROUPS

AIDS HEALTH SERVICES ADVISORY COMMITTEE: The Joint Task Force recommends that the AIDS Health Services Advisory Committee coordinate its efforts with the CARE Council and the Health Services Branch of the San Francisco Department of Public Health's AIDS Office. The AHSAC should assess possible duplication of functions with the San Francisco HIV Contractors Association.

AIDS PREVENTION ADVISORY COMMITTEE: The Joint Task Force recommends that the AIDS Prevention Advisory Committee coordinate its efforts with the HIV Prevention Planning Council and the Prevention Branch of the AIDS Office and evaluate possible overlap with the HIV Prevention Planning Council.

COALITION FOR HEALTHY SEX: The Coalition for Healthy Sex has identified a need for formal lines of communication between elected officials, the Department of Public Health and Coalition members. The Coalition has requested that it remain autonomous both from the AIDS Office, specifically, and from the Department of Public Health, generally.

COALITION FOR POSITIVE FAMILIES WITH CHILDREN: The Joint Task Force notes that the Coalition for Positive Families is developing formal ties to the AIDS Office and has a history of working with the Department of Social Services. The Joint Task Force recommends that the CPFC coordinate with the HIV Youth Advisory Committee on issues affecting both groups' constituencies.

HIV HEALTH SERVICES PLANNING COUNCIL (A.K.A. CARE COUNCIL, RYAN WHITE COUNCIL): The Joint Task Force recommends that the CARE Council receive input from the AIDS Health Services Advisory Committee, San Francisco Community Clinic Consortium, the People of Color Advisory Committee and the San Francisco HIV Contractors Association. The Joint Task Force suggests that the Council, or one of its subcommittees, might be the appropriate forum for soliciting input from DPH contractors about the AIDS Office contracting system and for working with the AIDS Office to revise the contracting system.

HIV PREVENTION PLANNING COUNCIL: The Joint Task Force recommends that the HPPC receive input from the AIDS Prevention Advisory Committee and the People of Color Advisory Committee.

HIV YOUTH ADVISORY COMMITTEE (A.K.A. HIV YOUTH TASK FORCE): The HIV Youth Advisory Committee recommends that all key planning and advisory groups have mandated youth representation. The Joint Task Force recommends that the Committee coordinate with youth-focused advisory and planning groups such as the Coalition for Positive Families with Children. The HIV Youth Advisory Committee completes its tenure at the end of 1994. However, in November of 1994, San Francisco voters overwhelmingly approved a policy of creating a Youth Commission. We support this concept and encourage this body, if and when formed, to include HIV issues within its scope and continue the work of the HIV Youth Advisory Committee. If this is not accomplished, the Joint Task Force suggests exploring the formation of a permanent citywide youth advisory body on HIV issues.

PEOPLE OF COLOR ADVISORY COMMITTEE: The Committee and the Joint Task Force recommend implementation of the recommendations of the *People of Color and HIV/AIDS Report* released in 1993.

SAN FRANCISCO COMMUNITY CLINIC CONSORTIUM: The Consortium sees a need to review the equitability of distribution of CARE funds to the Department of Public Health and among contractors. The Joint Task Force recommends that the Consortium formally discuss issues, concerns and possible solutions with the HIV Contractors Association, the CARE Council, the San Francisco Health Commission and other groups.

SAN FRANCISCO HEALTH COMMISSION: The Commission sees a need to address Department of Public Health priority areas such as TB, STDs, HIV/AIDS, homelessness and violence.

SAN FRANCISCO HIV CONTRACTORS ASSOCIATION: Some duplication of functions has been identified between the AIDS Health Services Advisory Committee and the San Francisco HIV Contractors Association. The Contractors Association sees its task as assisting and representing contractors, and sees the AHSAC's task as assisting the AIDS Office. The Contractors Association sees a need to review current contract procedures within the Department of Public Health, including, but not limited to the AIDS Office. The Joint Task Force recommends that the Contractors Association coordinate its efforts with the AHSAC and the San Francisco Community Clinic Consortium. The Joint Task Force also recommends that the Contractors Association identify means for bringing issues and concerns before the CARE Council, the Health Services Branch of the AIDS Office, the Department of Public Health, the San Francisco Health Commission and other appropriate bodies.

GENERAL RECOMMENDATIONS:

- The Joint Task Force recommends that the City and County of San Francisco develop a model for communication and coordination among citywide HIV/AIDS policy and advisory groups and between these groups and public agencies, in

particular the Department of Public Health, the AIDS Office and the Department of Social Services.

- The Joint Task Force recommends that the City and County of San Francisco or the Department of Public Health disseminate existing conflict of interest guidelines to policy and advisory groups, and that it ensure consistent adherence to these guidelines.

- The Joint Task Force recommends that the City and County of San Francisco or the Department of Public Health distribute to each citywide HIV/AIDS policy and advisory group clear guidelines that explain the purpose, roles and responsibilities of each group and its participants.

- The Joint Task Force recommends that the above-listed groups communicate and coordinate efforts with the HIV/AIDS Housing Network and the Housing Opportunities for People With AIDS (HOPWA) Loan Committee (see Appendix B).

APPENDIX D

REVIEWED DOCUMENTS, INTERVIEWS AND PUBLIC FORUMS

APPENDIX D
REVIEWED DOCUMENTS, INTERVIEWS AND PUBLIC FORUMS

The Joint Task Force was charged with evaluating HIV services and identifying gaps in services and unmet needs in the City and County of San Francisco. To complete this evaluation, we reviewed a large number of documents and previously published reports and received input through interviews, focus groups and public forums. The abbreviations in the text of Appendix E correspond with the citations listed below. Copies of reviewed documents and notes or minutes from interviews, focus groups and public forums are available from the AIDS Office: 25 Van Ness, 5th Floor, San Francisco, CA 94102, Phone: 415 554-9000.

DOCUMENTS:

CNAA *1994 CARE Needs Assessment Addendum.* Spring 1994. HIV Health Services Planning Council.

CNG *Call for a New Generation of AIDS Prevention for Gay and Bisexual Men in San Francisco.* 8/94. (Study funded by the San Francisco Department of Public Health.)

CSA *San Francisco Eligible Metropolitan Area Fiscal Year 1994 Application for Supplemental Grant Funds Under Title I, Ryan White CARE Act of 1990.* 1/13/94. AIDS Office, San Francisco Department of Public Health.

CTA *The Mayor's Call to Action on the HIV Epidemic.* 1/90. The Mayor's HIV Task Force.

GS *Draft Goal Statements for Inclusion in the Comprehensive Plan for HIV Services.* Amended 9/16/94. Long Range Planning Subcommittee of the HIV Health Services Planning Council.

HIS *HIV Incidence and Prevalence in 1992, Summary Report from an HIV Consensus Meeting.* 2/12/92. Surveillance Branch, AIDS Office, San Francisco Department of Public Health.

HP *San Francisco Five Year Housing Plan.* 5/25/94. AIDS Office, San Francisco Department of Public Health.

HPPC — *Goals for HIV Prevention Planning.* 9/12/94. HIV Prevention Planning Council.

HPPC2 — *San Francisco HIV Prevention Draft Plan.* 10/11/94. (Executive Summary, Draft. 10/26/94.) HIV Prevention Planning Council.

PAE — *Projections of the AIDS Epidemic in San Francisco: 1994-1997.* 2/15/94. Seroepidemiology and Surveillance Branch, AIDS Office, San Francisco Department of Public Health.

POC — *People of Color and HIV/AIDS: Planning for Treatment and Services in San Francisco.* 1993. Asian/Pacific AIDS Coalition, American Indian AIDS Institute, Black Coalition on AIDS, Latino Coalition on AIDS/SIDA, and the AIDS Office, San Francisco Department of Public Health.

ROG — *Review of Goals for HIV Services and Assessment in Goal Achievement.* 9/10/94. HIV Health Services Planning Council.

SPY — *Youth and HIV Disease in San Francisco.* 5/93. AIDS Office and Special Programs for Youth, San Francisco Department of Public Health.

TCM — *Letter from the American College of Traditional Chinese Medicine to the HIV Health Services Planning Council.* 9/19/94. Howard Moffett, Clinic Director, American College of Traditional Chinese Medicine.

VOE — *Voices of Experience: A Study of Client Experience with HIV Services in San Francisco.* 1/94. The HIV Health Services Planning Council and the San Francisco Department of Public Health.

VS — *Vision Statement in Response to Voices of Experience: Recommendations for a Comprehensive Client-Centered System of HIV Care.* 9/12/94. Long Range Planning Subcommittee of the HIV Health Services Planning Council.

WS — *HIV Seroprevalence and Risk Behaviors Among Lesbians And Bisexual Women: The 1993 San Francisco/Berkeley Women's Survey.* 10/19/93. Surveillance Branch, AIDS Office, San Francisco Department of Public Health.

INTERVIEWS, FOCUS GROUPS AND PUBLIC FORUMS:

AH — *Ambassador Hotel.* 9/13/94. Focus group with residents, staff, outreach workers and service providers at the Ambassador Hotel, a residential hotel that houses low-income people, many of whom have AIDS and many of whom are substance abusers.

DSS *Street Outreach to Homeless People, Department of Social Services.* 9/27/94. Interview with Hunter Mills, Street Outreach Worker for the Department of Social Services.

KP *Kaiser Permanente.* 9/23/94. Interview with Janet Tobacman, Director of the Kaiser Permanente San Francisco HIV Health Education Department.

MSC *Multi-Service Center (South).* 9/27/94. Interview with Rayna DiModica, Director of the Multi-Service Center (South), a shelter and service center for homeless people.

MX *Matrix Program.* 9/27/94. Interview with Paul Martin of the Mayor's Matrix program, regarding services for homeless people with HIV/AIDS.

PF *Public Forum.* 9/13/94. Hosted at City Hall by the Joint Task Force.

PAG *Citywide HIV/AIDS Policy and Advisory Groups.* 8/31/94. Focus Group hosted by the Joint Task Force.

PN *History of the San Francisco Model.* 5/4/94. Interview with Pat Norman, Executive Director of Institute for Community Health Outreach, hosted by the Joint Task Force.

RKD *Ralph K. Davies Hospital.* 8/31/94. Interview with Marilyn Barkin, Director of the HIV Institute at Davies Medical Center.

SM *St. Mary's Hospital.* 9/19/94. Focus Group with Daniel Ostrow, Director of HIV Services, Denny Smith, HIV Patient Coordinator, two Social Workers and the HIV Patient Advisory Group from St. Mary's Hospital HIV Services.

SOS *California Institute for Community Outreach: Street Outreach Services.* 9/15/94. Interview with Pat Norman, Executive Director of the Institute for Community Health Outreach (ICHO) and Edwin Florentino, Director of the Street Outreach Services (SOS) Project, a collaboration between ICHO, Haight-Ashbury Free Clinic, Asian AIDS Project, Tenderloin AIDS Resource Center, 18th Street Services and Proyecto ContraSIDA Por Vida.

TW *Tom Waddell Clinic.* 9/27/94. Interview with Marta Rebolledo, Outreach Worker at the Tom Waddell Clinic, regarding services to homeless people with HIV/AIDS.

WAN *Women's Focus Group.* 8/23/94. Hosted at City Hall by the Women's AIDS Network and the Joint Task Force.

YS *Youth Services.* 9/23/94. Interviews with Sean Sasser of Youth Empowerment Services (YES), Jim Neiss and Antigone Hodgins of Bay Area Young (BAY) Positives, Ellen Moore of Cole Street Clinic and BAY Positives, and Janet Shalweitz of the Department of Public Health.

APPENDIX E

RECOMMENDATIONS FROM REVIEWED DOCUMENTS, INTERVIEWS AND PUBLIC FORUMS

APPENDIX E
RECOMMENDATIONS FROM REVIEWED DOCUMENTS, INTERVIEWS AND PUBLIC FORUMS

In this appendix, we note the unmet needs and recommendations for improving HIV services that were identified in documents, interviews, focus groups and public forums reviewed by the Joint Task Force (listed in Appendix D). These recommendations do not emanate from the Joint Task Force; in most cases, the language below is taken directly from these reviewed sources. We reproduced the findings of previously published reports because we found that their recommendations have in many cases gone unheeded or unimplemented even after several years. Thus, many of these recommendations are also included in the body of this report.

It is important to note that many of these recommendations are specific to individual target groups or populations, reflecting the population-specific focus of most reports and meetings. Not every population group, however, has been the subject of a document or forum. It should therefore not be assumed that this list of recommendations and needs is exhaustive, or that the concerns of every group are adequately or equally represented.

Recommendations herein are cited to the documents, interviews, focus groups and public forums reviewed by the Joint Task Force, with multiple cites listed when the issues arose more than once. Citations are identified below by the abbreviations listed in Appendix D. They are organized as follows:

I. Overarching Needs
II. Program-Specific Needs
III. Administrative Needs
IV. Overarching Recommendations
V. Program-Specific Recommendations
VI. Administrative Recommendations

I. Overarching Needs

- Sensitive, equitable and available services for all, including particular population groups (as defined by culture, race, ethnicity, class, gender, sexual orientation, immigrant status, language, age, health status, etc.). Simplified, comprehensive intake; easy access to services (AH, DSS, GS, MX, SM, TW, VOE, YS).
- Effective outreach, including one-on-one recruitment into services by people of the same community; the response to this need should include adequate peer training, financial compensation, participation in the designing of the service system and an atmosphere of respect and support (SOS, YS).

- More services in the homes of persons with AIDS (GS, POC, VS).
- Reliable and easily-accessed information about treatment and service options, particularly clinical trials (GS, POC, SM, VS).
- Help with needs that are not specifically HIV-related (e.g, housing, clothes, furniture, money management, drug and alcohol treatment, psychiatric services) (AH, POC, WAN).
- Increased emphasis on the family unit and extended family network (POC, WAN).
- Recognition and utilization of existing community support and organizational structures (e.g, community churches, tribal organizations, community elders, women, etc.) (POC, WAN).
- Increased and more conveniently located services for young people (CNAA), especially:
  - youth living with guardians or in abusive situations;
  - youth who are without homes or stable living conditions;
  - youth with multiple diagnoses;
  - youth abusing substances but not in recovery or not able/willing to stay clean from drugs or alcohol;
  - youth who are intimidated by the system.
- Increased services of all kinds for women (PF, WAN).
- Response to the profound issues impacting a community living with a major epidemic for over ten years: self esteem, hope, trust and caregiver burn-out and mortality (SM).
- Increased access to services for people *not* infected with HIV so there is no incentive to become HIV-infected in order to access support; programs with qualifying criteria that require a specific degree of illness or multiple diagnoses should address this issue. (For example, because of the scarcity of substance abuse treatment slots, programs with slots reserved for clients with substance abuse issues *and* an HIV diagnosis may unintentionally create an incentive for clients who are desperate enough for treatment to become infected.) (AH).
- Increased services for the families of PWAs; these services should not cease when the infected family member dies (AH, WAN).
- Increased services and information in jails and prisons. More outreach and support programs in jail and increased support and compassion on the part of corrections officers needed (PF, WAN).

II. Program-Specific Needs

- **Primary Medical Care**

  Members of all ethnic groups express the need for increased access to primary medical care (CNAA); medical care at clinics or doctors' offices is still the greatest need, with persons with higher CD4 counts and men generally expressing the greatest need (CSA, VOE). One barrier to access is that private providers cannot afford to serve people who are uninsured or indigent (RKD); MediCal reimbursement does not keep pace with costs (PF). There is a need for private primary care providers to collaborate among themselves and with other providers

to address gaps in service and possible ways to address those needs (PAG, RKD). It should be noted that downsizing and cutbacks in patient care have already occurred due to the acknowledgement of managed care (PF). Respite care services have been underutilized (ROG). There is a need for a residential dementia care setting for people with moderate dementia who can remain in the community (ROG).

- **Dental Services**
  Although enrollment at the University of the Pacific dental program doubled in July 1994, dental services are still seen as a major need, particularly among men (CSA, VOE), white men and women, Native Americans, gay/bisexual injection drug users and people who have known they were infected for less than a year (CNAA).
- **HIV-Antibody Testing**
  HIV-antibody testing services must be expanded for young people (CNAA, SPY, YS) and women (WAN). "Risk assessment" criteria at HIV-antibody testing sites should include woman-to-woman transmission (WAN).
- **Complementary Care**
  Care through non-western medical traditions is seen as a great need by persons of "other" ethnicity, Asian/Pacific Islanders, people younger than 25, men and gay/bisexual injection drug users (CNAA, CSA). Increased alternative treatment services are needed in order to address long waiting lists at current agencies (GS, PF).
- **Prevention/Education**
  Prevention/education was seen as a top priority in 1990 (CTA) and the need for continued attention to the prevention needs of vulnerable populations is continually expressed (PAG). There is a need for more prevention/education services for women (WAN) and for homeless people (TW). Despite youth-specific media campaigns, there is a need for expanded youth services (SOS); the number of new infections among young gay and bisexual men and other high-risk youth indicate this need for youth prevention/education efforts, particularly efforts that use trained peer outreach workers (CNG, PAE, SOS, YS). Also, the number of women who report needle sharing or unprotected sex with bisexual men and male injection drug users and the number of lesbians who engage in high risk activities indicate a need for expanded prevention/education efforts among these populations (WS). There is a need for increased outreach to prisons and the school system (SOS); school programs should include all aspects of health, and should make condoms available in schools (SPY, WAN, YS).
  Prevention/education funders must increase their sensitivity to variances within populations (e.g., class issues within an ethnic or racial group) (CNG, SOS). Media outreach is ineffective; need to change current model from media campaigns to more direct outreach (SOS). Programs must be culturally appropriate and culturally specific; "multicultural" approaches may be economically sound but do not meet the needs of diverse cultures (SOS). Funding for increased experimentation and evaluation of new prevention

methodologies is also needed (CNG). Needle exchange programs were encouraged in 1990 (CTA) and are still seen as a critical need today (POC).

- **Case Management**
  Case management that is client-centered and coordinates ongoing financial and other needs for clients among care providers is needed (DSS, GS, ROG, VOE, WAN). This need was expressed as early as 1990 (CTA) but still is seen as unmet (CSA, VOE). There is a need for in-patient, discharge and out-patient case management services in private primary care facilities; many of these services have been cut in recent years (RKD). There is also a need for increased client advocacy (GS).
- **Housing**
  An adequate supply of permanent and affordable housing is needed (CTA, GS, ROG, WAN), including rental assistance and subsidy programs (CSA, VOE). There is a need for housing that includes mental health and other support services (GS, SM), and that includes family members (POC). Housing services are seen as the greatest need among homeless people, people living in hotels, people living in halfway houses (CNAA), current and former substance users, women, people with multiple diagnoses, and people who were recently incarcerated (AH, SM, TW). People younger than 35 years express a particular need for temporary housing services (CNAA). African Americans, persons of "other" ethnicity, Native Americans, women and those who were infected via blood products express a particular need for finding a place to live (CNAA, SPY, WAN, YS). Substance abuse and mental health issues contribute to security problems in housing programs (AH). Agencies need to address the issue of homelessness and substance abuse relapse (MX), as well as the housing needs of people who are unwilling to enter into treatment programs (AH, MX). Adequate housing for people who are HIV-positive and asymptomatic is also difficult to access (MX). Emergency or transitional housing slots for women often have more rigorous eligibility criteria than slots for men; given the difficulty many providers express in filling beds for women with HIV/AIDS, eligibility criteria for women's beds should be more flexible (WAN).
- **Day Care, Respite Care and Hospice Care**
  Neither day care nor emergency respite care needs are being adequately met (PF). The City does not have enough hospice beds (PF). Housing providers do not have the funding or support to coordinate adequately with hospice care providers (PF).
- **Substance Abuse Treatment**
  Drug treatment availability "on demand" was a goal in 1990 (CTA). Today, this need has yet to be addressed (GS). There is a need for expanded drug treatment services, especially for women, youth, Latino men (with a specific need for outpatient treatment), Native Americans, African Americans and heterosexual injection drug users and their sexual partners (CNAA, CSA, HIS, SPY, VOE, WAN). Relapse among people with HIV must also be addressed (HIS). A specific need is noted for treatment programs that accept women with their

children (WAN). The combination of HIV, substance abuse and mental health must be addressed in service delivery (GS, PF, WAN).

- **Mental Health, Emotional and Practical Support**
  Caregiver support and therapy and counseling services are inadequate in communities of color (CSA, POC, VOE); counseling is also seen as a great need for people younger than 25 and gay/bisexual injection drug users (CNAA, YS). There is a critical need to develop "care for the caregivers" programs and to address emotional and psychological issues such as self esteem and larger community well-being (CNG, VOE). Women need a forum in which they can discuss their issues in dealing with HIV (WAN, YS). There is also a need for mental health services for infected and affected families (PF). A major need has been expressed for buddy/companion services, especially for heterosexuals (CSA, VOE). Injection drug users cited support as a major unmet need (CSA, VOE). Help with housework is also expressed as a great need for heterosexual injection drug users (CNAA).
- **Spiritual Counseling**
  Support is needed for pastoral care and spiritual counseling, especially at the points of HIV-antibody testing, in substance abuse interventions and in hospitals (PF). There is a need for a directory of spiritual counseling services (PF).
- **Transportation**
  There is a need for better transportation services, particularly among women (CSA, GS, VOE). Transportation is seen as a greater need by people over 35 years, people of "other" ethnicity, African Americans, heterosexuals and gay/bisexual injection drug users (CNAA).
- **Child Care and Foster Care/Adoption**
  There is a need for child care and foster care/adoption assistance, particularly among women (CSA, GS, VOE, WAN).
- **Benefits and Financial/Money Management Assistance**
  Benefits assistance is a need, particularly among women, people of color, youth (CSA, SPY, VOE), Asian/Pacific Islanders and people who have known of their infection for less and one year (CNAA). Women have expressed a particular need for financial assistance and money management, although 50% of both men and women expressed this need in a 1993 survey (CSA, VOE, WAN). In a recent needs assessment, money management services are seen as a greater need by people 35 years and older and by women and financial assistance is seen as a greater need by those younger than 35 years, persons of "other" ethnicity, African Americans, and gay/bisexual injection drug users (CNAA).
- **Food and Nutritional Support/Vouchers**
  There is a need for food and nutritional support, particularly among African Americans (CSA, VOE). Food services are seen as a greater need for those 35 years and older, people of "other" ethnicity, gay/bisexual injection drug users, and those who have known they were infected for over three years (CNAA).

III. Administrative Needs

- **Allocation of Funds**
  In order to avoid creating budget crises for private and government agencies, there is a need to increase the efficiency of fund allocation (MSC). High staff turnover inhibits consistent and efficient service provision (MSC).
- **Technical Assistance to Service Providers**
  This was seen as a need in 1990 (CTA) and is still surfacing as an unmet need, particularly among population-specific service providers (HPPC). Specific technical assistance needs include organizational development, evaluation skills, personnel issues, grantwriting and fundraising (HPPC, PAG, POC, WAN).
- **Long Range Planning**
  There is a need for long range planning, though it should be noted that the AIDS Office and the CARE Council have begun such a process (RKD, ROG).
- **Data Needs**
  There is a need for additional demographic data about the following San Francisco populations: gay men, bisexual men, lesbian women, bisexual women, legal and undocumented immigrants, transgendered people and homeless people (HPPC2). Epidemiological information is needed about youth and HIV/AIDS, with a specific focus on street-based youth (SPY, WAN). Additional data is needed about youth-specific treatment regimens, the progression of HIV disease in young women, service models for youth and youth access to care (SPY, WAN). Additional information is also needed about woman-to-woman transmission, technology to prevent the transmission of HIV through oral-vaginal sex, and the different effects of therapies on men and women (WAN). The HIV Prevention Planning Council recommends the development of a comprehensive mandatory system of data reporting (HPPC2).

IV. Overarching Recommendations

- The CARE Council has recommended fostering cooperation and collaboration between systems and departments providing services that overlap with HIV services, such as substance abuse, criminal justice, housing and mental health services (GS, VOE, VS). HIV services should be organized as a coordinated unified system (VOE), including a centralized intake system (PF). Eligibility criteria should be consistent for similar services (VOE).
- People with HIV should be included in all levels of planning in the service delivery system (AH, GS, POC, VOE, VS, YS). It is important to recognize that individuals and sectors of affected communities may choose not to participate in HIV services; because service providers will not be able to attest to the needs of these groups, planning groups must commit to seeking their input and representation directly (PF).
- Forced collaboration does not foster cooperative efforts among providers (SOS). Collaborations should focus on best serving the needs of the community, not the needs of the bureaucracy (SOS).
- All service delivery must look at the entire family system, not just the person with

HIV disease (PF).

- Establish links between pediatric AIDS services and other children's service providers (PF).
- Increase the number of women with HIV on agency staff and boards of directors (WAN).
- Promote an entrepreneurial spirit in providing service and filling service gaps (PF).
- In the *1990 Mayor's Call to Action*, the following suggestions for addressing cost reimbursement were made (CTA):
  - Insurers should broaden their definition of covered care to include attendant, respite and day care;
  - Reimbursement rates for sub-acute care must be raised;
  - MediCal should revise reimbursement guidelines to reflect the types of health care required by people with HIV and AIDS.
- Managed care programs must be willing to pay for AIDS care (RKD).
- Insurers should set up common risk pools in order to share in the risk and must avoid redlining areas (RKD).
- In addition to the needs and recommendations listed elsewhere in this Appendix, young people have made the following recommendations for addressing gaps in youth services:
  - Support education and service programs designed by and for youth, using peers, especially youth with HIV, as role models (SPY, WAN);
  - Promote advocacy around young people's health, self-respect, body image and sense of self in relation to community (YS);
  - Mandate ongoing youth participation in key policy-recommending, advising, and planning bodies (YS);
  - Education and service programs for youth should incorporate HIV into other pressing issues for youth, including substance use, sexual abuse, pregnancy, employment, school and personal relationships (SPY). Education and service programs should also incorporate specific developmental issues young people have while living at home (YS);
  - Initiate an HIV prevention and health service needs assessment that uses surveys and focus groups to assess successes and gaps in current services for youth (SPY);
  - "We need to train professionals to work with youth and youth to work with professionals" (YS).

  This model for youth service delivery can apply to most other population groups in the epidemic.

V. Program-Specific Recommendations

- **Primary Medical Care**

  Ensure access to early primary care for all people with HIV (GS). Analyze current standards of practice for gender bias in diagnoses (PAG). Expand attendant and skilled nursing care for home health care (CSA).

- **Dental Services**
  Provide comprehensive dental services to all people with HIV and promote systemwide awareness that all people with HIV should receive a dental evaluation (GS).
- **Complementary Care**
  Define alternative medicine using the National Institutes of Health Office of Alternative Medicine's definition: nutrition, diet and lifestyle/behavioral changes, mind/body control therapies, traditional and ethnomedicine therapies, structural manipulations and energetic therapies, pharmacological and biological therapies, and bioelectric therapies (TCM). Bring together acupuncture and non-traditional approaches with western models of care (PF). Support clinics where these therapies can be combined, particularly so that patients do not experience interruptions in alternative care if they must enter the hospital (PF). Increase education and information for both patients and providers on the types of alternative treatments available (PF).
- **Prevention/Education**
  Assess risk for prevention/education purposes based on mode of transmission and behavior, not group identity (HPPC2). HIV risk reduction for injection drug users must also address issues of safer sex (HPPC2). Target prevention research proportionally to transmission risk (HPPC2), especially among young people (SPY). Repeat prevention messages frequently, concentrating on consistent and complementary messages that also promote maintaining safe behavior (CNG, HIS, HPPC2, PAE). Expand and enhance youth outreach efforts both to schools and to youth-focused programs outside of schools, such as Job Corps programs and group homes (SPY, WAN). Prevention efforts for all populations should emphasize participatory methods, small groups and repeated encounters (HPPC, HPPC2). Prevention/education efforts should address social and psychological issues underlying behavior change for individuals and communities (HPPC2). Support prevention/education in sex clubs by increasing communication and coordination among prevention/education organizations, sex club owners, and patrons (CNG, PAG).
- **Case Management**
  Expand case management for transgendered persons, women, homeless people and substance abusers (CSA, WAN).
- **Housing**
  Improve services provided within housing programs through more extensive staff training around issues of HIV/AIDS, increased case management and client advocacy, reduced staff turnover, and implementation of stress reduction programs (AH, DSS, MSC). Implement the *San Francisco Five-Year Housing Plan*. This plan calls for the following:
  - Focus scarce housing resources on persons with disabling HIV/AIDS (HP, MX);
  - Develop programs to provide housing for very low income persons with HIV/AIDS, with special consideration for projects that provide services to

homeless people (HP);

- Progressively convert housing leased by nonprofit agencies to owned property in order to ensure long-term availability and affordability (HP);
- Develop a centralized housing information and placement service in order to make access more equitable (HP, PF);
- Develop housing linked to support services that can meet State licensing requirements (AH, HP);
- Develop HIV-specific housing linked to support services that targets persons with multiple disabilities, such as mental illness, substance abuse, and AIDS Dementia Complex (AH, HP);
- Develop "mixed projects" which set aside units in standard affordable housing developments for people with HIV/AIDS (HP);
- Use "tenant based rental assistance" to house homeless persons and to prevent people who are currently housed from becoming homeless (HP);
- Establish a technical assistance and capacity building program in order to create linkages between service providers and increase the number of providers able to provide housing and related services (HP).

- **Substance Abuse Treatment**
  Expand detox program slots, especially long-term detox for women (WAN). Increase access to detox programs for homeless people (TW). Relax substance abuse program requirements regarding meeting attendance, timeliness, and other similar criteria in order to make treatment programs more accessible (WAN). Expand methadone maintenance to people with HIV and investigate funding for methadone treatment, particularly around slots for people who are between GA and SSA benefits (CSA, MX). Integrate HIV prevention into drug and alcohol treatment programs (CSA).
- **Mental Health, Emotional and Practical Support**
  Develop youth-specific counseling and support group programs using peer models and self esteem motivation, with specific focus on increasing needs as the disease progresses (SPY). A specific need is identified for support groups for young lesbian, bisexual or questioning women (WAN). Expand day care, emergency respite care and mental health services for people with HIV and their families (PF, WAN).
- **Legal Services**
  Expand legal services to people of color and women (CSA, WAN, VOE).
- **Food and Nutritional Support/Vouchers**
  Increase availability of vouchers for utilities, food and personal needs (CSA, GS). Provide nutritional services and education as part of the comprehensive continuum of HIV care (GS).

VI. Administrative Recommendations

- **Allocation of Funds**
  Review the funding of community-based organizations so they can offer competitive salaries, particularly in order to recruit people of color (POC).

- **Technical Assistance to Service Providers**
  Establish cultural competency training and assurance practices. Service providers within existing agencies should be trained to become more culturally competent (MSC, POC).
- **Long Range Planning**
  Create an ongoing planning/evaluation body that is convened, staffed and sustained by the City and County of San Francisco (PN).
- **Evaluation**
  Review monitoring of programs; the continued decrease of department personnel to monitor approximately 200 HIV service contracts with the City has resulted in a continual series of crisis management situations. The effectiveness of the program and the satisfaction of the users of the services should be key elements in the evaluation of programs (PF, SOS). The AIDS Office's evaluation of cost of care, specifically fee-for-service contracting, should be reviewed (PF). Delays in receiving funding must be addressed (PF). Quarterly reports should be carefully monitored to determine the effectiveness of a program (SOS). Epidemiological studies on HIV prevalence should inform the evaluation of prevention efforts (HPPC). Contractors who do not participate in a complete program evaluation should face standardized penalties (HPPC). Uniform evaluation and assessment tools should be established for prevention/education efforts (HPPC2).

APPENDIX F

GLOSSARY OF TERMS

APPENDIX F
GLOSSARY OF TERMS

This is a limited glossary of terms used in ***A Second Decade Response to HIV/AIDS in San Francisco***. The glossary is not meant to be inclusive or definitive; it is meant only as a brief guide to the usage of some terms in this report that are often confused with others or that are not clearly defined in general usage. Most terms are not HIV-specific.

access: The degree of ease with which the consumer can secure health or social services. Along with availability, access is a key criterion used to measure the adequacy of a health care or social service system.

acute care facilities: Short-term facilities or hospitals that provide crisis intervention for physical or psychological symptoms and/or disease.

AIDS Dementia Complex: A condition of deteriorated mental capacity that is characterized by marked decline from the individual's former intellectual level; often accompanied by emotional apathy.

attendant care services: Professional or para-professional services which may include routine and skilled nursing care, rehabilitation services and homemaker or home health aide services.

availability: The degree to which health care or social services, including facilities and personnel, are in place and readily accessible to all consumers.

bereavement services: Grief and loss counseling or support services for partners, family and friends during the dying process or after the death of a loved one.

board and care: A residential facility providing 24-hour non-medical care and supervision to non-elderly adults.

case management: Client-centered services that link clients with health care and psychosocial services in a manner that ensures timely, coordinated access to appropriate levels of care and support services, and continuity of care. Services include: assessment of the client's needs and personal support systems; development of a comprehensive, individualized service plan; coordination of the services required to implement the plan; client monitoring to assess the efficacy of the plan; and periodic re-evaluation and adaptation of the plan as necessary. Money management and representative payee

services are also considered to be forms of case management. Case managers help clients move through and cope with established systems and protocols.

centralization: The process by which information or services are brought into a shared and concentrated base. This concept may be applied to a very wide range of procedures including, but not limited to: case management for social/medical services, intake/ assessment processes and computerized data collection systems.

client advocate/advocacy: Individual or services working on behalf of client in order to promote protection of civil rights and other needs experienced by clients. Examples include assistance in accessing existing social services, applying for benefits, or facilitating wills or other legal matters.

client-centered service: Service conducted in an interactive manner responsive to individual client needs. Encourages client to set her or his own individualized service agenda, rather than relying on a preconceived agenda set by the service provider. Focuses on developing goals with the client rather than simply providing information or imposing the program's goals.

clinical trials: Investigations of the effects of medications on volunteer subjects. The purpose is to seek information regarding the product's safety (Phase I clinical trials) and efficacy (Phase II/III clinical trials).

collaboration: Joint efforts by individuals or agencies that are not themselves directly connected. Often, a more structured, higher level of association than "coordination."

community: A grouping of people with identity in common (such as culture, race, ethnicity, class, gender, sexual orientation, language or age) who often work together or identify as a social unit within the larger society.

community-based organizations (CBOs): Organizations delivering program services locally or as close to the consumer base as possible. Usually, CBOs are incorporated as nonprofit agencies governed by Boards of Directors that oversee the legal, fiscal and administrative responsibilities of service provision.

consolidation: The process of merging two or more organizations or specific services within or among community-based organizations by dissolving existing ones and creating a smaller number of new entities or services.

continuum of care: The full spectrum of health, educational, social and related services. A system that ensures continuity of care is designed and implemented to maintain services despite changes of site, caregiver or method of payment.

coordinated care: Care that is planned and implemented so as to form a cohesive therapeutic program.

cost per unit: The total program costs divided by the number of units of service provided.

counseling: Helping people plan action that will benefit themselves or others. Unless designated as group counseling or couple counseling, the word is used to describe one-on-one discussions. This service may be provided by licensed, certified or peer-identified personnel.

culturally competent (culturally appropriate): Culturally competent organizations are characterized by acceptance and respect for difference, continuing self-assessment regarding culture, careful attention to the dynamics of difference, continual expansion of cultural knowledge and resources, and a variety of adaptations to service models in order to better meet the needs of diverse populations. Such agencies view diverse populations as distinctly different from one another and as having numerous sub-groups, each with important cultural characteristics. The definition of cultural competence should also be used to apply to other dimensions of diversity such as race, ethnicity, class, gender, sexual orientation, immigrant status, language, age, health status and disability.

demographic data: A set of information that includes, but is not limited to a person's age, gender, sexual orientation, race/ethnicity, housing situation and address. This data may include personal identifiers such as name or social security number.

discharge: Release from confinement, custody or care.

epidemiology: The study of the incidence, distribution and control of disease within a population, community or region.

gatekeeper: The individual charged with reviewing client information with regard to program eligibility criteria, in order to determine if the client may be admitted to a program.

General Fund: Public tax revenues that are collected and distributed under the authority of the Mayor of San Francisco.

harm reduction: A substance abuse intervention model that encourages reducing the harmful consequences of substance abuse (e.g, learning how to clean works in order to prevent the transmission of HIV through needle sharing), as opposed to models that posit complete abstinence from drugs as the only successful outcome of intervention or treatment.

hospice care: Nursing care, counseling, emotional support, physician services and "comfort care" provided to terminally ill patients in their own homes or in other residential settings.

housing services: Services that may include: emergency housing vouchers, assistance in locating and obtaining suitable permanent or transitional shelter (including assistance with paying costs associated with finding a residence), and rental assistance.

in-patient treatment: Medical care that is provided in a hospital or acute care facility.

late- and end-stage AIDS: The stage of the HIV disease process in which the prognosis is six months or less until death.

low-income housing development corporations: Agencies that purchase, renovate and manage properties for people with low incomes.

managed care: A health care delivery system that is based on holding down the costs of health service by utilizing economic incentives and by limiting the availability of health service. Typically, managed care programs pay providers on a per patient, rather than a "fee-for-service" basis, and use primary care physicians or other providers as "gatekeepers" (see definition above) to more specialized care.

methadone maintenance: Provision of long-term counseling and methadone to address opiate (usually heroin) addiction.

mission-driven budget: A budgetary planning and implementation process focused around the limited or essential personnel and expenses necessary to carry out the mission of an organization or department.

mixed projects (in housing): Affordable housing developments that set aside some units for people with HIV/AIDS.

multiple diagnosis: A combination of medical, behavioral or social factors/issues that must be addressed simultaneously (e.g, substance abuse, mental health issues and HIV).

non-ambulatory: A condition in which a person is unable to walk or be mobile without assistance.

outpatient case management: Case management services for individuals who do not reside in a hospital or other inpatient care facility.

outreach services: Services that are provided in a community or street setting and are designed to reach targeted or hard-to-reach populations with prevention messages,

informational materials and/or referrals for related programs. Outreach efforts aim to make services accessible to individuals who might not otherwise seek them.

peer-based outreach: Outreach activities or service provision by providers who are identified as members of the target population or community.

prevention/education services: Services that promote, educate and reinforce a person's understanding of the risks of acquiring or transmitting HIV, identify behavior changes already implemented, or address barriers to efforts to reduce risk. Services include: HIV-antibody testing when attached to support or counseling services providing interpersonal skills training in negotiating and sustaining appropriate behavior change; and multi-level community attempts to change the social norms that influence individual behavior, including media campaigns or small-group interventions and mobilizations.

primary medical care: Routine, non-emergency, non-inpatient, non-specialized medical care.

psychosocial issues: The combination of psychological and social factors that affect an individual. These factors include, but are not limited to, mental and emotional health, economic resources, housing status, substance abuse history and personal support systems.

rental subsidies: Ongoing financial assistance for rent.

residential settings: Facilities in which service provision is based upon a short- or long-term agreement to live within a given residence.

respite care: Non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of a client or client's dependent.

satellite centers: Facilities that are located apart from a central site of service provision. Such facilities aim to extend the availability and accessibility of service for diverse populations.

seroconversion: The production of antibodies in response to HIV infection. The term is commonly used to describe the process of progression from HIV-negative to HIV-positive status.

skilled nursing care: Therapeutic health services provided by a licensed practitioner or certified home health agency in a home or other residential setting.

standard of care: The level of consistently applied methodology that must be followed in the delivery of services.

tenant-based rental assistance: Financial assistance for rent paid on behalf of a client at a location the client chooses.

transgendered: An umbrella term that includes male and female cross dressers, transvestites, female and male impersonators, pre-operative and post-operative transsexuals, transsexuals who choose not to have genital reconstruction, and all persons whose perceived gender or anatomic sex may conflict with their gender expression, such as "masculine-appearing" women and "feminine-appearing" men. Gender identity is different from sexual orientation.

Additional copies of this report may be obtained through the San Francisco Department of Public Health's AIDS Office: 25 Van Ness, 5th Floor, San Francisco, CA 94102. (Phone: 415 554-9000)